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ADEQUACY OF VA FUNDING

HEARINGS

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

SECOND SESSION

SEPTEMBER 9 AND 20, 1988

Printed for the use of the Committee on Veterans' Affairs

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ADEQUACY OF VA FUNDING

FRIDAY, SEPTEMBER 9, 1988

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS
Washington, DC.

The committee met, pursuant to notice, at 8:13 a.m., in room SH-215, Hart Senate Office Building, Hon. Alan Cranston (chairman of the committee) presiding.

Present: Senators Cranston, DeConcini, Graham, Murkowski, Thurmond, and Specter.

OPENING STATEMENT OF CHAIRMAN CRANSTON

Chairman CRANSTON. The meeting will please come to order. Good morning and welcome to this morning's hearing on the adequacy of VA funding and personnel resources to meet current and future needs of patients seeking care from the VA health-care system. I am especially pleased to welcome the many witnesses here this morning and very much appreciate the help of the VA in making so many VA field personnel available to the committee.

This hearing will provide a vitally important opportunity for the committee to gather information from a variety of sources that will enable us to come to a more complete understanding of the current state of VA health care.

In recent months, we have received a flood of complaints from VA doctors, nurses, and other health-care professionals, as well as affiliated medical schools, that the Agency is not fulfilling its responsibility to provide prompt and effective health care to eligible veterans; that there are long waits for certain outpatient clinic appointments; that there is no money for equipment replacement; that drug and supply stores are dangerously low; and that there are long delays for needed surgeries, especially those requiring prostheses.

The testimony submitted today from the veterans' service organizations and from other organizations familiar with the operations of the VA echo those concerns; but we also hear and read statements from the top of the VA suggesting that there really is no problem.

Qualified health-care professionals are the backbone of the VA health-care system. It is essential that adequate numbers of qualified staff are available to care for our Nation's veterans, yet we hear repeatedly that there are major recruitment and retention problems for many VA health-care personnel.

For example, we have heard frequently about the closing of beds because of an inability to recruit nurses, about long delays in filling prescriptions because of an inability to recruit pharmacists, and about VA medical facilities contracting out certain diagnostic procedures because they can't recruit certain specialists.

In contrast, we hear high-ranking VA officials say that, although the VA may not have everything it wants, it has everything it needs to provide good care.

On the recruitment and retention front, Congress has for the last dozen years enacted one proposal after another, mostly over strong administration opposition, to give the VA special tools to meet its personnel needs. Over this period, the VA has rarely if ever taken the initiative to propose any major new recruitment and retention authorities.

For 7 of the last 8 fiscal years, Congress has appropriated far more money than the administration has requested for the continued operation of the VA's Department of Medicine and Surgery. Since 1982, we have provided a total of $1.6 billion more for VA medical care than the administration requested. Well over half of that total—$972 million—was appropriated for the last 3 fiscal years.

For fiscal year 1989, which begins in a few short weeks, the administration requested $10.3 billion for VA medical care. At our March 4 budget hearing, the VA testified that that funding level provided "ample resources to furnish care to all veterans expected to apply for and to be in need of care."

Thus, the Congress had every reason to believe that amounts appropriated above the level requested would go to enhance the Agency's ability to meet veterans' health-care needs. Yet, we now learn, in an August 4, 1988, VA internal document entitled "Chief Medical Director's Task Force Report," that a budget shortfall of $819 million for fiscal year 1989 is being estimated under the administration-requested budget.

This task force report, which I will include in today's hearing record and copies of which are on the press table, describes in detail 18 options to reduce the budget shortfall for fiscal year 1989 and also lists 68 other options for consideration.

[The task force report appears on p. 149.]

Chairman CRANSTON. This morning's testimony will show that some of these have already been implemented piecemeal to deal with the current fiscal year 1988 shortfall. Among these 86 options, many of which could seriously impair services furnished to veterans, are proposals to close some medical centers, reduce inpatient admissions, lay off hospital employees, shut down vet centers, restrict provision of prosthetics, eliminate VA kidney transplants and certain forms of dialysis care, restrict organ transplants, eliminate or greatly reduce the provision of drugs, and cut back sharply on nursing home care.

Most of the items I have listed are on the short list of 18. Given the projected shortfall and the need to look at options such as these, it now appears that the VA's March testimony was erroneous and misleading.

Plainly, resources called for in the President's budget were not ample, nor could that budget have provided for services to all veterans expected to apply for and be in need of care. I must conclude that the VA withheld from Congress vital information showing the adverse effect the President's fiscal year 1989 budget would have on the Agency's ability to provide medical care for veterans.

Judging from the current conditions in VA medical programs, which could not have developed overnight, I must also conclude that the VA has been withholding accurate information from Congress for a number of years. If one looks generally at the VA budget for any 1 fiscal year, nothing ominous or menacing stands out.

It is true that certain equipment purchases have been delayed or the maintenance of a particular item has slipped, but such actions in and of themselves are not unusual or alarming. In any enterprise, unexpected expenditures arise and priorities will shift to accommodate them.

Indeed, until recently, VA facility directors would have said that, although they did not have everything they wanted or needed, they were generally able to furnish safe, quality health care to veteran patients. Perhaps the surroundings where care was provided were not as luxurious as found in some private hospitals, but the care itself was as good if not better than what could be found in many non-VA hospitals.

Today, many VA facility directors will answer differently when asked how they are doing. They will say that they will be able to make it through this fiscal year with the help of a $31.7 million supplemental fiscal year 1988 appropriation that I proposed and the Senate passed on August 4, despite OMB's explicit refusal to submit a request for the funding needed to fund the requirements of Public Law 100–322 enacted on May 20.

But, as I believe we will hear today, these directors and other VA medical center leaders are very uncertain about the coming fiscal year. Although Congress has appropriated $215 million more than the administration requested for fiscal year 1989, the Agency still is over $600 million short of the funding needed according to its own internal estimate.

VA facility directors are saying that they can no longer purchase necessary equipment or make essential repairs, that they cannot allow supplies of drugs and essential materials to dwindle to unacceptably low levels. They are saying that they may not be able to furnish safe health-care to all veterans who seek care, particularly with the rising demand for those services; and they are saying that they need special funding in order to implement the mandated universal precautions against infection.

The small, but I fear growing, group of directors are saying that, if the current trend continues, they will no longer be proud of their association with the VA health-care system.

I expect that our hearing today will provide us with a better understanding of the severity of the problems being faced, of the effects on patient care and the availability of services, and of the alternatives which are available to us to resolve this crisis in VA health-care.

I am committed to finding a way to meet veterans' health-care needs and will do all I can to try to obtain a supplemental appropriation when the continuing resolution comes to the floor later this month.

Finally, I want to welcome Al Ptak, the new Minority Staff Director, to his first committee hearing. I am sure Al will be a worthy successor to Tony Principi, who left the committee last month to resume residence in California.

Frank, you have an opening statement, I trust?

OPENING STATEMENT OF SENATOR MURKOWSKI

Senator **Murkowski**. Yes, Mr. Chairman. Good morning. I am very pleased to have the opportunity to join with my friends and many of the witnesses and guests at today's hearing on funding for veterans' health-care programs.

Let me commend you, Mr. Chairman, for your continued commitment to veterans and, of course, for holding this important hearing this morning. I, too, want to welcome Al Ptak, the new chief counsel and staff director for the minority. Al is a Vietnam veteran, a graduate of our Naval Academy, spent some time with the CIA, and has had a distinguished career; and we look forward to your input, Al, as counsel for the minority.

To start, Mr. Chairman, I want to thank the many VA field staff members who came at a great distance to be with us. I think your participation is going to be very important in this morning's hearing.

It is always useful—extremely useful—to hear the concerns of those who are actually out on the front line providing the treatment to our Nations' veterans; and I applaud your fine and very dedicated efforts to fulfill your mission in these challenging fiscal times.

As the chairman indicated, the purpose of the hearing is to examine the fiscal situation within the Veterans' Administration's Department of Medicine and Surgery. Under the outstanding leadership of Dr. John Gronvall, the VA's Chief Medical Director, the VA has continued to provide health-care services to an increasing number of veterans with a relatively consistent budget—a very, very difficult task to do indeed.

The fiscal year 1988 VA health-care budget is over $10 billion. These funds are used to operate 172 hospitals and other health-care facilities. All these hospitals are, however, different hospitals and have unique problems and unique needs based upon patient population, geographic regions, and types of services offered.

Therefore, it is difficult to generalize and inappropriate to do so with regard to the situation at one hospital to other health-care facilities. I believe it is fair to point out the reality that those of us on the committee recognize that there is no possible way that we can ever adequately repay the obligation that this Nation has to its veterans.

However, reality dictates that we must work with what we have, and that is the amount that is budgeted to the Veterans' Administration and the VA health-care system by the Congress of the United States. So, while we can never do enough, we have to work with what we have.

We have to continue to prioritize by examining the changing needs of veterans. Veterans' needs do change as they grow older. That is where we need the input from the veterans' organizations—those people who are on the front lines—to recognize and tell us where the priorities are changing and where the budget dollars should go. It is simply a fact that there is not unlimited funding in this area.

So, being realistic, which has been the posture of those of you who are testifying today and certainly of the committee, we have to maintain that reality. I believe that it is vital to keep in mind that despite some press accounts—particularly that have some seasonal association—which may indicate that category A veterans, those who under the law are required to be furnished hospital care are not—and I repeat are not—being denied VA medical care.

In some cases, there are delays experienced, and it is unfortunate. In some cases, these delays are too extensive. With all respect, however, I don't think we can or should say that a veteran has been denied care if he is not able to get nonemergency care the first or perhaps the second day he walks in the front door of a local VA.

The reality is that it is just not unusual to call up a private doctor and to be scheduled for an appointment several weeks later. Obviously, this is not the ideal situation, but veterans will be seen by the Veterans' Administration.

Today, Administrator Turnage will say that the funding situation is tight. I believe we will learn indeed that Mr. Turnage is correct in that statement. It is important to note that the VA has recognized the seriousness of the funding shortage for a long time and has a request pending before the Office of Management and Budget for a fiscal year 1989 supplemental appropriation.

Unfortunately, discussions of any budget, including the VA, takes place in the shadow of the total deficit which our Nation, of course, faces. Our Government is spending more than $1 trillion in fiscal year 1989. It is collecting about $144 million less than that.

As we know, the Government is unique in its budget process, where it debates the merits of revenues and expenditures and then seems to add whatever else it needs to the deficit; the Government is rather unique in that regard.

The most recent figures indicate that we are about $700 million away from a Gramm-Rudman-Hollings sequester. We need to focus on those figures when we consider a $10 billion medical care budget. Some veterans' service organizations and members of the Congress have stated that the Congress has been misled about the funding situation in the VA, a statement that has been communicated by our chairman.

I find this allegation rather troubling and, in fact, terribly ironic. During my tenure on this committee, I can recall submitting annual budget views and estimates to the Budget Committee which recommended increased funding for needed VA medical-care programs.

If I did not believe that more money was needed, I certainly would not have supported more funding for the VA. It was certainly not much of a surprise to me that the funding situation was tight. After all, we cannot expect the VA to continue to do more without more funding.

With respect to the VA's medical-care budget, I believe the committee would be remiss if we did not focus some attention on the question: What additional funds are needed? Why are additional funds needed? I would like to suggest a few answers.

Now, this isn't perhaps appropriate to say: I told you so, but I can recall that last spring, during the House-Senate Conference on H.R. 2616, the Conference Committee very frankly ignored the budget implications when they voted to include in the conference report new health-care entitlements and programs which will cost about $117 million in fiscal year 1989.

I strongly objected to some of those new programs because I simply did not know, and I still don't know, where the money would come from to pay for them. Frankly, it was and is somewhat irresponsible for this committee and the House committee to recommend new mandatory health-care programs when they don't mandate additional appropriations to pay for them. And this is a problem, ladies and gentlemen, that we all share.

Although at times like this it may be easy and may be desirable to do so, we must not forget about the bipartisan budget agreement which we are currently operating under. In December of 1987, the executive branch and the Congress agreed to limit the amount of increases in spending for discretionary programs.

Now, we all know that the VA medical care account is a discretionary account. That was a hard decision, but deficit realities made that bipartisan compromise a necessity.

Another factor is the lag which takes place between the time the VA budget is prepared and the time an appropriation is enacted. Medical care delivery and technology are changing so rapidly that often the VA simply does not have time in the budget process to take changing circumstances into account.

For example, we had the implementation of AIDS safety precautions as provided for the Centers for Disease Control, which began in August of 1987. In preparing the budget for that year, the VA did not consider the cost, primarily because the CDC guidelines were not even being developed at that particular time.

Finally, and perhaps more importantly, the VA is not in a unique situation with regard to funding and staffing shortages. One can hardly pick up a paper; I am sure you all saw the Washington Post on September 8—"Meet These People on the Fast Track"—without learning about the national nursing shortage.

It is not unique to the VA; it is all over the country, and it is a problem, and it is unfortunate. It is just that: it is a national problem. Just yesterday, ads appeared in several newspapers throughout the country referring to the nursing situation. As I have indicated, the ad was in this case for military nurses and was paid for by the U.S. Armed Forces.

Now, some community hospitals have closed in this country and were aware of that, due to shortages and funding shortfalls. So, I would like to point out to you that we cannot simply isolate the VA system from the national health-care situation. It is all health care. One is an obligation specifically of this country to our Nation's veterans, but it must share in the reality and the climate associated with health care in general.

Again, I look forward to hearing the varied testimony today. I believe we must work, as we have, in a bipartisan fashion without finger pointing, to ensure the continued success of the VA healthcare system.

Before closing, I want to make reference to a comment that has been generalized because of the season that somehow the administration has been less than sensitive to the needs of our veterans. I think the commitment of President Reagan to elevate the Veterans' Administration to Cabinet status should put that matter to rest once and for all.

I happen to have been down at the White House when the President made that announcement, and there is absolutely no question in my mind about the commitment the President has toward that particular additional Cabinet post because he individually happened to believe it was in the best interests of our Nation's veterans.

It certainly occurred under President Reagan's watch. I think it is indicative of his particular and unique concern and commitment to our veterans as evidenced by that Cabinet status elevation.

Finally, before closing, I would like to note that we have some good news on the veterans' employment issue with regard to Vietnam veterans. Last week, we noted that the Department of Labor released the numbers for August showing only 3.6 percent of Vietnam-era veterans were unemployed. The rate for nonveterans the same age was 4 percent. That is not as good as we would like it, but it is certainly moving in the right direction.

Finally, I have a reference here to some charts that I would ask the witnesses to comment on during the course of the hearing because I think they reflect some of the generalities that have been expressed to me from time to time as to the agenda of the hearing as it focuses in on specific areas of veterans' care.

Chart No. 1 [see p. 184], which I would ask that the young lady point out and assist me on, accurately reflects the VA's medical care budget since 1977. You will note that that budget has remained fairly constant. Now, the red line indicates inflation adjusted dollars. So, as you can see, the current dollars vis-a-vis the inflation dollars indicates a relatively constant movement across the years.

This chart was prepared at my request by the Veterans' Administration.

Chart No. 2 [see p. 185]. Now, this covers an issue that is going to be addressed this morning; and that is the average number of operating beds. We have had press accounts of late indicating that the VA is not operating the mandatory level of hospital beds.

In 1981, the Congress mandated that the VA operate 90,000 beds. As the chart indicates, the VA has not met that level since the enactment of the law; that is granted. But the reality is that it may not be necessary to do so. As you can see by the chart, it shows that the VA hospital bed levels took their steepest decline—their steepest decline—between 1977 and 1981.

Now, the blue line indicates that the number of patients furnished inpatient hospital care has declined at a faster rate than bed levels, yet the VA continues to treat more veterans. So, simply put, the VA can care for more people now because it has become more efficient at doing so. This is due to increases in outpatient care and, of course, a decrease in average lengths of stay.

So, I would invite the witnesses to reflect on their interpretation of these factual realities as evidenced by the accompanying charts.

Finally, chart No. 3 [see p. 186], is in the area of employment levels. Now, although we all recognize that there is a shortage of nurses in the VA system as well as the private sector, and that recruitment and retention are the biggest challenges for the system, this chart—and this was also prepared at my request by the VA—illustrates that the number of registered nurses has increased slightly since 1977. In fact, the total number of nurses, which includes registered nurses, licensed practical nurses, and nurses' assistants, is over 60,000.

With that, Mr. Chairman, I thank you for the opportunity to make an opening statement. I see we have other members of the committee who have appeared, and I wish you well as we proceed with the testimony of the witnesses.

Chairman CRANSTON. Thank you very much, Frank. Senator Graham, I believe you have an opening statement.

OPENING STATEMENT OF SENATOR GRAHAM

Senator GRAHAM. Thank you, Mr. Chairman. I do not have a written statement, but I would like to make a few remarks, in part based on a recent experience spending a day at the VA regional office in St. Petersburg, FL, which happens to be the largest regional office in the Veterans' Administration.

I recognize that much of the focus today is going to be on the access and quality of health care provided through the current Veterans' Administration system. The newspaper article which Senator Murkowski just raised relative to the nursing shortage, I think, is instructive in several ways.

One of the ways in which it is instructive is that it asks the question: What were people thinking about 20 years ago when there was a fundamental change in the employment opportunities, particularly at the professional level for women; and why did we fail to realize the impact that that was going to have on the traditional professional careers for women—teaching and nursing?

A second question which that raises is: What are some of the issues today that we similarly need to be focusing on because they will have very clear, significant impacts 10 and 20 years from today? It is on one of those issues that I would like to make a few comments.

That is, the Veterans' Administration population to be served is moving. In the States which have traditionally had the largest number of veterans, the veteran population is declining. In other States, it is increasing rapidly. In my State of Florida, we are adding approximately 5,000 veterans per month to our State's population. We have had a net increase, that is, veterans moving into the State minus those who are either deceased or have left the State, approximately 20,000 veterans per year throughout the decade of the 1980s.

So, we have a demand being driven by mobility and change of location of the veterans in the face of a health care system which has been primarily based on fixed, stable, in-place institutions operated by the Veterans' Administration.

Another fact is that the veteran population is aging. In our population in Florida of approximately 1.4 million veterans, over 600,000 of those are World War II veterans. The average age of the World War II veteran today is 66; it is older than that in our State of Florida.

We know that the cost of health care for persons over 65 is, in the general population, two to three times on average what the cost of health care is for the population under 65. So, we have a large, older World War II population which is entering the most expensive period of their lives in terms of health care and, therefore, a likely demand on the VA system.

What are the strategic options that we need to be considering today in the face of these realities that are going to be increasingly apparent and significant over the next decade? One alternative is to accept the fact that we are going to have a growing disparity in the level of health care available to America's veterans, based on where in America those veterans live. In our State of Florida, your chances of access to a VA hospital for a nonservice-connected disability are about one-third less than your chances of admission to a VA hospital in other States in our country.

That gap will certainly grow as these disparities in population continue to grow.

A second option is an urgent and massive program to provide health-care facilities in the areas of the country where the veteran population is rapidly increasing. In our State of Florida, we currently have one new VA facility—a significant VA facility—under way in the West Palm Beach area. Others are planned for the Orlando, panhandle, and Southwest Florida areas; but it will be many years before those other facilities are able to accept veterans for medical services.

A third option is to begin to look for some new approaches, and some of these, I recognize, are controversial and have not been favored by either the representatives of the veterans or the Veterans' Administration. But I believe that unless we are to accept either the disparity of treatment or the tremendous and urgent financial cost of limiting that disparity through the current traditional method of providing health care, we have got to look at some new approaches, such as contracting for services using health-care facilities and human capabilities which are currently available in ways that will meet the needs of veterans, so that we can say to our veteran population: You will have access to the same level and quality of service wherever you live in this Nation.

Mr. Chairman, I believe that the issues that we are going to raise today should be an important chapter in an overall look at our strategic direction in terms of providing health care for America's veterans in the reality of the 1990s and beyond; and I congratulate you on holding this hearing.

Chairman **Cranston**. Thank you very much for a very helpful statement. Senator Specter, do you have any opening remarks?

Senator **Specter**. Senator Thurmond has joined us, and I would be glad to yield to my senior colleague.

Chairman **Cranston**. I was recognizing you because you were here earlier.

Senator **Specter**. Thank you, Mr. Chairman.

Chairman **Cranston**. Senator Thurmond, we welcome a statement from you.

Senator **Thurmond**. I have a brief statement, Mr. Chairman.

OPENING STATEMENT OF SENATOR THURMOND

Senator **Thurmond**. Mr. Chairman, it is a pleasure to be here today to receive testimony involving oversight of the Veterans' Administration medical care program. The Veterans' Administration currently operates 172 major medical centers, over 200 outpatient clinics, and over 100 nursing homes. Given this size, delivery of health-care services is no small task.

On the whole, the VA health-care program has served the veterans of this country well. However, we must continue to seek ways to make a good system even better.

As part of the oversight functions of this committee, we must take a look at VA programs to ensure that they are operating in a sound manner. Today, we will take a look at the medical care program, and I look forward to hearing some of these distinguished speakers before I have to leave to go to the floor on the textile bill; but I shall read the record later. Thank you very much.

Chairman **Cranston**. Senator Specter?

OPENING STATEMENT OF SENATOR SPECTER

Senator **Specter**. Thank you, Mr. Chairman. I am delighted to participate in these important oversight hearings, and I compliment the chair and the ranking member for the diligence which they have exercised on the oversight matters in the course of the past 7½ years since I have been on the committee.

I think it is very important, to state it bluntly, that we keep politics out of these hearings, notwithstanding the fact that we are less than 2 months away from a presidential election. The care for veterans and the underlying substantive matters are too important to get them involved in politics, even if it is a presidential election year.

When the site of this hearing was announced in room 216 in the Hart Building, I was a little perplexed at first; I didn't know quite where to go. For the 7 years and 9 months that I have been on this committee, I have always gone to room 418 in the Russell Building, except for the occasions when we have a large number of veterans, and we meet in Dirksen 106.

As I look over this crowd, we could have fit in room 418, I do believe. We don't have the superabundance of cameras, which probably we would have had less if we had done this at 7 a.m. instead of 8 a.m. But I do think that we really have to focus on the substance and not on the politics, even though it is the political season.

I believe there are major problems in the Veterans' Administration, and I believe that is well known. I have visited the hospitals in my State on a continuing basis since I have been in the U.S. Senate. And when there are reports of complaints—there are reports of complaints all the time—there are reports of complaints when things are going very well.

When you have the volume of patients which the Veterans' Administration hospitals have, there are going to be complaints. I have worked very closely with Administrator Tom Turnage over the course of the past years, and I have not found a more diligent Administrator or Secretary in the Federal Government. He has a lot of problems, and I have brought him a lot of problems. And when I have, he has always made a real effort to solve them. He hasn't always done it perfectly, but I don't think he really has the resources that he needs.

That is not a surprise to this committee, and that is not a surprise to the Congress. Administration heads and Department heads go into the Office of Management and Budget and submit budgets, and we all know that they are pared back. We have seen key administration officials come to hearings on a repetitive basis and testify in a way in which they really must, given the budget constraints of the administration.

We do not hear in committee hearings the same kinds of positions which they advance earlier in the budget process, but we understand that is their job. I think this committee has done a good job in the course of the past 7½ years of adding on funds, as has been noted earlier today; and I have voted very often for those add-ons.

I have felt that the Office of Management and Budget did not have a real appreciation of the needs of the Veterans' Administration hospitals, and I think they do not until this day; but I think Administrator Turnage does, and I think that we can help him. I think that these hearings are useful to focus on the kinds of problems that we have so that, when we go back to the budget, we can try to take care of some of these issues.

I would hope that the thrust of what we are doing today and in the future will be on a very constructive level of assessing the problems and trying to get them solved and not in a sense of finger-pointing or blame because I do not think that is really the issue.

As Senator Murkowski noted, President Reagan has pushed for Cabinet status; I think that is a good symbolic move. I think it shows the President's directions; he can't possibly know all the details of the problems. I think Administrator Turnage does. I think he is a good soldier, who has done a good job, but he is marching in a tough army with limited resources. I think that this committee will help him, and I hope that that is where we head in these hearings. Thank you, Mr. Chairman.

Senator **THURMOND**. Mr. Chairman, I am going to have to leave. Could you give me half a minute before I leave?

Chairman **CRANSTON**. Certainly.

Senator **THURMOND**. Mr. Chairman, I just want to say that, on behalf of General Turnage, I think he has done an excellent job. I called on him about 2 weeks ago on an emergency case; I believe it was late at night, and he responded very diligently and got results. This man is capable; he is conscientious; he is dedicated. And I just want to pay him this compliment at this time.

We may need more resources. I have been on this committee ever since it was first formed; I was ranking member when it was first formed. And I don't know of any Administrator who has done as fine a job as General Turnage; and I just wanted to pay him that tribute.

Chairman CRANSTON. Thank you all very much. I would just like to say briefly that, over the years that I have been active on this committee, it has behaved basically in a nonpartisan, bipartisan way. We have been together most of the time, and there is nothing unique about the criticisms that are now coming because it happens to be a Republican administration.

I have served on this committee during the presidencies of Nixon, Ford, Carter, and now Reagan; and in all those years, I have found myself in some form of combat with the administration. Specifically this morning, I stated on the recruitment and retention front that Congress has for the last dozen years enacted one proposal after another, to give the VA special tools to meet its personnel needs, mostly over strong administration opposition; that includes the Democratic administrations as well as the Republican administrations.

As far as I am concerned, what we are dedicated to in this hearing and the work on this committee is meeting our obligations to America's veterans. And this hearing is to determine whether or not that is the case now; and if it is not the case now, what do we need to do about it.

We will now proceed with the representatives of the service organizations, and I would like to welcome Mr. John F. Sommer, Jr., Director, National Veterans' Affairs and Rehabilitation Commission of the American Legion, accompanied by Mr. Samuel Walsh, Assistant Director, National Legislative Commission; Mr. Dennis Cullinan, Assistant Director, National Legislative Service, Veterans of Foreign Wars of the United States of America; Mr. David W. Gorman, Associate National Legislative Director for Medical Affairs, Disabled American Veterans; Mr. Gordon Mansfield, Associate Executive Director for Government Relations of the Paralyzed Veterans of America, accompanied by Mr. Richard Fuller, Associate Legislative Director, and Ms. Tina Alvarado, Associate Legislative Director; and Mr. Thomas Sherwood, Director of Health Policy and Planning, Vietnam Veterans of America.

I would like to thank each of you for joining us this morning. I would like to ask each of you to rise now so that I can swear you in as witnesses.

[Whereupon, the witnesses were duly sworn.]

Chairman CRANSTON. I thank you.

Senator MURKOWSKI. Mr. Chairman?

Chairman CRANSTON. Yes?

Senator MURKOWSKI. With regard to the reference on services that you have seen expand during your tenure, I would certainly agree. And I think you would agree with me that one of the difficulties is the reality that, as we press the issue of more services for the VA, the responsibility of funding those services is also a reality and a responsibility of the Congress. And I think therein lies a good portion of the problem. Thank you, Mr. Chairman.

Chairman CRANSTON. Certainly, there is a shared responsibility, but most of the time we have been in a situation—and this again is through various administrations of two different political parties—

where the administration dominated in these matters to a significant degree by the OMB which has sought to prevent resources being made available. The Congress very often, on a bipartisan basis, has felt that more resources were needed to meet our obligations to veterans.

I think we are going to lead off with Sam Walsh and John Sommer. So, would you please proceed first?

STATEMENT OF JOHN F. SOMMER, JR., DIRECTOR, NATIONAL VETERANS' AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION, ACCOMPANIED BY SAMUEL J. WALSH, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE COMMISSION

Mr. Sommer. Thank you, Mr. Chairman. The American Legion appreciates the fact that you scheduled today's hearing. We feel that it is very much needed, and we appreciate this opportunity to express our concerns about the inadequate funding in the Department of Medicine and Surgery and the resultant problems which are forcing the closure of beds, curtailment of certain treatment programs, elimination of treatment for many nonservice-connected veterans, excessive waiting times for admission, the closing of some clinics, and the myriad of other things, many of which you listed in your opening statement.

It is a fact that the budget for this Department has been decremental over the past several years. Our experience verifies this as our field representatives survey medical centers which have continually attempted to do more with less. And what we are witnessing today is the cumulative effect of several years of funding deficits coupled with the fact that the demand for care continues to increase, and new programs are legislated without the required money to operate them.

What we do not understand is how top VA management can state that the Department of Medicine and Surgery is well-funded and that it gets all that it needs to do its job well, particularly when we are receiving telephone calls from all over the country as well as letters about the discontinuation of treatment of veterans, the closing of rural clinics, curtailment of prescription medications, and many other problems that have been previously mentioned.

These are resulting from medical center directors having to drastically cut programs in order to stay alive because of the inadequate funding. It has been estimated that the shortfall for fiscal year 1989 may be as much as $819.3 million up to $1 billion for the Department of Medicine and Surgery.

Unless some action is taken with respect to a supplemental appropriation or something of the like, we can only anticipate that even more draconian actions will be taken throughout the medical care system to reduce spending, and we understand that contingency plans are now being developed to accomplish this end. The shortfall in funding for medical programs is real, and no amount of wishful thinking or rhetoric will make it otherwise.

We sincerely trust that the VA officials will explain to this committee the true extent of the problems that are being experienced in the medical care system and that they will accurately portray the budgetary requirements of the Department of Medicine and Surgery.

Mr. Chairman, that completes our summary.

[The prepared statement of Mr. Sommer appears on p. 188.]

Chairman CRANSTON. Thank you very much. Mr. Cullinan?

STATEMENT OF DENNIS M. CULLINAN, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. CULLINAN. Thank you, Mr. Chairman and members of this committee. On behalf of the entire membership of the Veterans of Foreign Wars, I wish to thank you for affording us this opportunity to present our views concerning the severe problems now facing the VA's Department of Medicine and Surgery with respect to funding and personnel shortages.

Mr. Chairman, I have already submitted for the record the VFW's statement addressing these issues, which presents our views in general, as well as an addendum which presents particular instances of diminished or substandard health care being provided at certain VAMCs. Rather than reading from these two documents at this time, I will now cite additional concrete examples of the inadequate funding and management of DM&S.

This material was obtained over the phone from a sampling of our department service officers throughout the country. Additionally, our field representatives have provided us with information concerning additional problems they have encountered in their more recent surveys at VA facilities. And we will also provide the committee with a list of names of veterans who have been recently denied VA health care by the VA.

Loma Linda, California VA Medical Center. Two wards closed due to nursing shortages; 6 to 8-hour ambulatory care waiting time. General Turnage dedicated a 60-bed addition to the nursing home care unit at this facility in the summer of 1987. In February 1988, our field representatives noted that the 120 bed combined facility then housed only 69 patients due to staffing shortages.

New Orleans, Louisiana VA Medical Center. Ran out of money each quarter of this fiscal year.

Oklahoma City, Oklahoma VA Medical Center. Inadequate funding for prosthetics services. The chief of staff characterized the operating suites as dangerous and obsolete.

Fort Howard, Maryland VA Medical Center. ICU closed due to nursing shortage; 37 of 85 registered nurses authorized were short.

Boise, Idaho VA Medical Center. Prosthetic services tapped out in funds before the end of each quarter.

Albuquerque, New Mexico VA Medical Center. Ward closed due to nursing shortages.

Wilmington, Delaware VA Medical Center. Ward closed; long delays in outpatient scheduling.

San Antonio, Texas VA Medical Center. Less than 90 beds of 120 bed nursing care unit filled because of lack of nurses. No replacement equipment money available to this facility.

White River Junction VA Medical Center. Cut beds 20 percent due to nursing shortages.

Boston, Massachusetts VA Medical Center. 169 beds vacant due to nursing shortages. $5 million in unmet equipment needs for items that have passed their life expectancy.

Cleveland, Ohio VA Medical Center. Radiology service on contract since it cannot be provided by the medical center in a timely manner.

Westhaven, Connecticut VA Medical Center. Monitoring equipment in surgical intensive unit considered unsafe. Chief of surgery would not personally undergo surgery there.

Fayetteville, North Carolina VA Medical Center. Nursing shortage of 25 percent.

Kansas City, Missouri VA Medical Center. Prosthetics funding shortages.

Muskogee, Oklahoma VA Medical Center. Cannot afford to treat non-service-connected outpatients.

Washington, DC VA Medical Center. Closed wards, then beds, due to budgetary and staff problems.

Seattle, Washington VA Medical Center. Staff shortages have led to recent discontinuance of outpatient treatment for nonservice-connected veterans.

Mr. Chairman, I could go on and on with this list of shortfalls and problems facing VA medical centers throughout the country. This is not representative of a select few for this is a nationwide problem.

The VFW has been arguing for years that there are severe shortages of funding and that the VA medical system would eventually come to a point where there is no more fat to be cut and that veterans would indeed be denied proper and timely care because of this.

We think that this time has unfortunately now arrived and that remedial action needs to be taken in the very near future if more veterans are not to be denied care. Thank you, Mr. Chairman.

Chairman CRANSTON. Thank you very much. Mr. Gorman?

[The prepared statement and addendum of Mr. Cullinan appears on p. 194.]

STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

Mr. GORMAN. Thank you, Mr. Chairman. Good morning. The DAV genuinely appreciates the opportunity to appear here this morning, and we are pleased to offer our views concerning the current and, more importantly, the future state of the Department of Medicine and Surgery.

We believe, Mr. Chairman, that testimony that the committee will hear today will, for the most part, be consistent and portray a health-care system that is in a state of fiscal crisis. In our view, the situation shows no signs of improvement or even stabilization. Rather, all indicators suggest a downward spiral is occurring which will result in a severe adverse disruption in the manner in which VA health-care services are provided to eligible veterans.

All of us familiar with DM&S are aware of the severe budget shortfall that will occur in fiscal year 1989, just 3 short weeks away. We have all heard the dollar shortages projected ranging anywhere from the $600 million plus to somewhere in the vicinity of $1 billion.

Mr. Chairman, putting aside these dollar amounts, all of the statistics and all of the complexities involved when attempting to gauge the needs of the Agency, some telling and very concrete facts do exist. With ever-increasing frequency, our office is being contacted by veterans detailing what they perceive to be a significant cutback or denial of medical services being provided by the VA.

Veterans complain of such things as denial of care, tremendous delays in having prescriptions filled, absurd delays in obtaining clinical appointments, waits of weeks—sometimes months—to be furnished prosthetic services and devices, or being referred to other VA facilities long distances from their homes because of the local VA's facility inability to furnish appropriate care.

We also hear occasionally from families of veterans who are desperate to arrange nursing home care, only to be told by the VA that there is nothing available in the VA or they have no contract money to place them in a community nursing home. We hear from veterans who want to know what they will do, where they will turn, when clinics or programs they have been participating in close down due to a lack of funds.

Veterans contact us in a panic when they are in acute need of medical treatment, only to be told to come back in 3, 4, or sometimes 6 months. Veterans ask us why a VA doctor suggests that they seek treatment from a private physician or a hospital that participates in the Medicare Program.

Mr. Chairman, these are real questions posed by real veterans, and they occur on a daily basis.

In order to get a better understanding of the situation occurring within the system, the DAV conducted a study of our national service offices pertaining to VA facilities within their individual States. We have compiled this information in the form of fact sheets and have furnished this committee with a copy of the results. It is not, however, a very encouraging picture.

Mr. Chairman, we also conducted a second survey about 3 weeks ago, which has resulted in our obtaining the names and specific circumstances of a number of veterans who have not, in our opinion, been furnished appropriate VA medical care. This information likewise has been provided to the committee.

Finally, Mr. Chairman, notwithstanding what is clearly a critical funding problem within DM&S, we must extend our sincere appreciation and thanks to the many dedicated employees of the VA who have thus far made the system work and allowed veterans to receive the health-care services they so desperately need and are entitled to.

We believe, however, that the resources have been stretched to the limit and there exists no further room for additional maneuvering or shifting of dollars. Mr. Chairman, this completes my testimony, and I will be more than pleased to respond to any questions you may have.

Chairman CRANSTON. Thank you very much. Mr. Mansfield?

[The prepared statement of Mr. Gorman and fact sheets referring to the State of California appear on p. 210.]

STATEMENT OF GORDON H. MANSFIELD, ASSOCIATE EXECUTIVE DIRECTOR FOR GOVERNMENT RELATIONS, PARALYZED VETERANS OF AMERICA, ACCOMPANIED BY RICHARD FULLER, ASSOCIATE LEGISLATIVE DIRECTOR; AND TINA ALVARADO, ASSOCIATE LEGISLATIVE DIRECTOR

Mr. **Mansfield.** Mr. Chairman, thank you and the members of the committee for holding this hearing on such an important matter. For Paralyzed Veterans of America's members, health care is not a luxury; it is not something that can wait. For paraplegics and quadraplegics, health care and associated medical services are the basis for life.

We all have acknowledged, I think, that there is a problem. PVA has testified previously about the lower budget request than necessary; about the fact that the Agency has had to eat pay raises, either in whole or in part; about the fact that productivity increases have come out of the existing budget; and about the fact that new programs have not been funded adequately.

We, too, feel that the problem is such that all the fat has been cut out; all the quick fixes have been taken; and we can't go much further without the system starting to self-destruct. The fact that nonrecurring funds are being used for recurring operation expenses has reached the point where the system cannot operate effectively.

PVA also has done a survey; and I would like, Mr. Chairman, to request that our entire testimony be included in the record, and I would like to refer to that.

Chairman **Cranston.** It will be.

Mr. **Mansfield.** Thank you, sir. We surveyed over 100 hospitals, and we came up with information in three areas.

First of all, veterans are being denied care. This is due to a lack of nurses or other medical care personnel. It is due to a stretchout in outpatient scheduling. It is due to delays for surgery. It is due to delays for prescriptions and supplies.

In our testimony, Mr. Chairman, we have included, for example, a sign that came to us that was up at the San Diego Outpatient Clinic. It says:

> Attention: Effective Monday, August 15, 1988, patients requiring urgent or unscheduled care will not be seen at this facility. These patients should report to . . .

We have a copy of a letter here to an ambulance service in Reno—Mercy Ambulance Service of Reno—saying:

> Dear Mr. Brady: As discussed in our telephone conversation today, we ask that Mercy Ambulance Service avoid bringing patients with suspected cardiac ischemia to the Reno VA Medical Center effective immediately.
>
> This medical center has no staff cardiologist and is unable to provide prompt and appropriate care for such patients. After these patients are assessed and stabilized at other community medical centers, we will arrange for their transfer to the VA on a space-available basis.

Another VA indication to a veteran, saying:

> Dear Veteran: A consultation was sent to one of our specialty clinics for evaluation of your medical problem. Currently, this specialty clinic is only accepting service-connected veterans for evaluation and/or treatment. For this reason, we are unable to schedule you for this clinic.
>
> We suggest that you seek care for this condition in the private sector at your own expense. I regret that we are unable to assist you with this request. I am enclosing a pamphlet that explains your eligibility for medical benefits.

Another area which is of specific concern, Mr. Chairman, to PVA members is that of prosthetics and supplies. I would suggest to you that prosthetics is a requirement for quality of life. I would also suggest to you that I would not be able to be here today if I didn't have adequate prosthetics supplied.

I would suggest to you that PVA's members—paraplegics and quadraplegics—who don't get adequate prosthetics or adequate supplies are not going to be able to live a quality life, are not going to be able to participate in the activities of daily life. They wind up being bedridden or confined to their own homes.

In the testimony we referred to, there are a number of incidents; and I would like to go over them.

It starts out with the fact that Mr. Turnage has been quoted as saying:

> We may not get all we want, but we get all we need to do our job well.

Reports from the field indicate that not only are veterans unable to get what they want, a whole lot of them are not even able to get what they need.

We refer, for example, to a memorandum from West Roxbury in Brockton VAMC which says—and this memo is dated May 12:

> There are many items which will have to be delayed until July, and some which may have to be delayed until October. We are working with very limited resources. Please be as conservative as possible in prescribing equipment. Something provided for one veteran will mean that another may have to do without.

And it goes on to point out that there is $10,000 remaining in the account for the remainder of the year.

There is another VAMC in Washington, DC, for example. Funding shortages for prosthetic services amount to $120,000. I happen to know about that one personally.

Another VAMC:

> There are no order backlogs, but prosthetics will exceed the allocated budget for fiscal year 1988 by approximately $40,000.

Another one in Gainesville, FL:

> As an example, the estimated dollar amount of reduction in inventory for drugs, medical supplies, and prosthetics as a result of inadequate funds in this fiscal year is $650,000.

Another one, Bay Pines, FL:

> We estimate there is a shortage of $450,000 for fiscal year 1989 in the prosthetics for this medical center.

Another one:

> The prosthetics account had to be augmented by $442,000 from reprogrammed equipment and maintenance accounts.

And this goes on and on.

Mr. Chairman, I think we have all acknowledged there is a problem. I think we all feel that we need to work together; and I think the point is that the medical center directors, the nurses—folks that you will hear from today—the folks out in the field have been carrying this system; and they have been working hour to hour, minute to minute, day to day to keep it working and try and provide services.

I think the leadership in Washington on Vermont Avenue needs to get in front of them and give them the resources they need. Thank you.

Chairman CRANSTON. Thank you. Mr. Sherwood?

[The prepared statement of Mr. Mansfield appears on p. 223.]

STATEMENT OF THOMAS A. SHERWOOD, DIRECTOR, HEALTH POLICY AND PLANNING, VIETNAM VETERANS OF AMERICA

Mr. SHERWOOD. Mr. Chairman and members of the committee, the Vietnam Veterans of America appreciate and thank you for the opportunity to present its views on the VA health-care system.

In a recent letter sent to the chairman of this committee, we point out that the single-most pressing problem and issue for the VA health-care system still is the quality of care. As we have heard, the system is in serious trouble. The interference of OMB, the problems of the allocation methodology, the lack of dollars, and the total system, all notwithstanding along with the inertia of a system simply too big to get out of its own way, we assert that poor quality of care relates directly to the medical centers' inability to sufficiently control, direct, and manage its own operations and resources.

The entire VA health-care system at the medical center level has come to a state of near institution paralysis where the medical center director and chief of staff dare not engage in decision making without checking with "CO," "Operations," "Regional," "Resources," or someone else.

You have heard our complete testimony on this crisis. This is on the record; therefore, I will highlight, directly some of the recommendations I want to make in this regard.

First, allow the VAMC to initiate and design its own annual budget first. The VAMC should do this within the DRG RAM rules, but the medical center director should be required to justify his or her budget request by tailoring VAMC resource needs to the veterans it serves and relative to the specific needs of the community where the center is located.

This may mean that the VA will have to contract for some services and/or sell other services to sharing hospitals or hospital systems in that same community. The relationship between the VAMC and the VACO should be one in which the VAMC sells services to VACO—that is, as a fiduciary intermediary—and VACO pays the medical centers to provide services for veterans.

Two, create a governing board of veteran consumers at each VAMC. The board functions should at least include holding the VAMC director accountable for all operations, the quality of care, the integrity of programs, resource management, program use for veterans' health care, and the implementation of policies related to carrying out that mission.

The role of the board is not just advisory. With recommendations one and two above, other than for informational purposes, it is not necessary to maintain either a national personnel ceiling or floor, or a bed ceiling. In a system that should be driven from bottom up instead of top down, the relative numbers of beds and personnel will emerge; and they will be real in terms of planning and identification of true resource needs.

As the VA Central Office is the fiduciary intermediary buying services directly from VAMCs, the medical regional offices are not necessary as another organizational line of authority. The district offices can improve their roles as guarantors to VA, that the VA Central Office is in fact getting the "bang for the buck" in terms of the quality of the products that the VA medical centers must produce.

Marketing and outreach strategies should be implemented as a means of forcing the VAMC to deliver a better product. The VA almost hides from those it serves and, therefore, has no means of accountability for what it does in this regard.

If the VA is concerned that too many aging service-connected veterans in this country will suddenly flood the system, then it may be appropriate to authorize service-connected veterans to use a health provider of his or her own choice at VA expense.

Finally, I direct your attention to our recommendations regarding the qualifications of medical center directors, the either/or option pass-through for certain programs, appropriate DRG support for mental health programs, and testing for nonservice-connected conditions with total support for service-connected conditions and their adjunct disabilities.

This ends our oral testimony. Thank you very much for the opportunity.

Chairman CRANSTON. Thank you very much for your testimony, which we appreciate very, very much.

[The prepared statement of Mr. Sherwood appears on p. 270.]

Chairman CRANSTON. And I thank you for the ongoing efforts of your organizations, both in Washington and in the field, in monitoring VA health care. The committee will be following up with the VA later in this hearing and in followup questions on the many specific examples that you have presented in your testimony on the current field problems.

I have one question I would like each of you to respond to. That is this: Is the current situation the worst you have seen for VA medical care funding in recent times?

Mr. SOMMER. Mr. Chairman, I can speak from my own personal experience only, and that is the fact that I have been in Washington 14 years with the national headquarters of The American Legion involved with the veterans' affairs and rehabilitation program; and this is the worst that we have seen as far as the number of complaints that we are getting from the field with respect to patients being turned away, problems with programs, problems in the funding of prescriptions, and many, many other critical complaints.

Also, the number of people who contact us relative to the individual problems that they are running into as increased, as well as the complaints that we receive from American Legion officials. So, I would have to say that we have not, in my experience in Washington, seen a problem of this magnitude.

Chairman CRANSTON. Thank you. Dennis?

Mr. CULLINAN. Mr. Chairman, the VFW sees this as being the culmination of many years of inadequate funding. What we are getting from the field is that through the years these various

VAMCs have been able to use nonrecurring funding to understock in areas such as prosthetics, to pay personnel costs, and cover other shortfalls in funding, and then make it up later in the year; but this has all taken away from what they have had available.

Now, we are at a point where this money is simply not there any more. We are getting, of course, more complaints from the field now; and our sense is that there is nothing more to put in. There is no money to be gotten from some other pot to make up the difference. So, it has gone from bad to bordering on desperate.

Chairman CRANSTON. Thank you. David?

Mr. GORMAN. Without question, Mr. Chairman, I think this is the worst that we have experienced and that we have been hearing about. In addition to all the examples we have submitted to the committee from our survey results, there is one thing we saw about 6 months ago that was probably the most telling thing that I have ever seen; and that was a conference call occurring between Central Office and the field, and we were able to review the transcript of that. It is almost like you could white out the names of the different directors on that conference call, and anybody without those names available would say: There go those veteran service organizations again complaining about the system; when, in fact, it was the managers of the system that were setting forth the problems they were having and their day-to-day experiences and the VA Central Office, really pleading their case and going into detail about what the problems were and seeking some kind of relief.

Mr. SHERWOOD. It definitely is the worst that I have seen. I have been with the Veterans' Administration for 14 years as a chief nurse, as an associate chief nurse, as a quality assurance officer, as an administrative assistant to medical center directors, and as a director of "one of the largest outpatient clinics in the VA system." So, I feel I know the system fairly well.

And I would say that it is definitely the worst that I have seen in terms of medical center directors trying to get programs going, trying to get programs done, and having to borrow from Peter to pay Paul, and the direct impact that that has on the patient. So, it is clearly the worst that I have seen.

Chairman CRANSTON. Thank you very much. Gordon?

Mr. MANSFIELD. Yes, Mr. Chairman. I think it is the worst we have seen. I travel around the country visiting PVA chapters, and when I do that, I visit the hospitals; and it is getting worse and worse. Traditionally, PVA officers have dealt with the benefits program. A year ago, we started a pilot program, which will be increased next year, where we have service officers dealing strictly with medical problems, not even dealing with the benefits problems.

I think the other thing that has to be realized here is that we know what the reality is; but what we have to be concerned about also is the perception of the veteran out there that it is going to get worse. We need to be able to give them reassurance and show them that it won't.

Chairman CRANSTON. Thank you. Frank?

Senator MURKOWSKI. Thank you, Al. I think that the input that you have given this committee is extremely important, and we are going to be responsive to it as we have been in the past. In the manner in which you represent the veterans, you are, of course, hearing from those veterans. You are getting the complaints; you are acting on their behalf, which is your function and the purpose of your organization—to represent veterans.

In the process of any bureaucracy, you are going to get inefficiencies, just as we see them in the military. Those of us who have been in the military griped about this and griped about that; and that is the process that brings about change. It is a healthy process.

Now, the realities of the VA today, I think, need specific qualification. Most of the testimony has been of a general nature. It has been helpful; but if we refer to the specifics of the obligation to category A veterans, with regard to the question of those veterans being denied care, I guess my question has to be: What evidence do you have specifically to assert a position that category A veterans are being denied care?

Now, a category A veteran—whom we know, but perhaps for the benefit of some in the audience who do not know—is that the VA is required to provide hospital care to category A veterans, which includes service-connected veterans, special category veterans, former POWs, those exposed to Agent Orange, ionizing radiation, World War I, Spanish-American, and Mexican War veterans, and nonservice-connected veterans who are unable to defray the cost of their care, which are those with annual income less than $15,833.00 for a veteran with no dependents.

Now, I noted that none of you have seen fit to comment on the charts; and I would appreciate your comments as to whether or not indeed the charts indicate the facts that the medical-care budget since 1977 has remained constant. Now, that is either an incorrect representation, or it is factual.

I am satisfied at this time, unless there is evidence to the contrary, that it is factual. Chart No. 4 [see p. 187], that I would refer to is with regard to the matter of the VA operation of the 90,000 beds. The blue line again indicates the number of patients furnished inpatient hospital care; it shows the decline at a faster rate than bed levels, yet the VA continues to treat more veterans.

I would ask for your comments on whether, in fact, the VA is doing more for more veterans because of efficiencies or increases in outpatient care and decreases in average lengths of stay. I would appreciate hearing from anybody who would either care to comment on the charts or their conviction that category A veterans are being denied care because that is an area that, if indeed we have factual evidence, I think that the VA and Mr. Turnage need to make every effort to correct. And it would be very helpful if we have that information.

Mr. GORMAN. Senator Murkowski, maybe I will start off.

Senator MURKOWSKI. Fine.

Mr. GORMAN. We do have documented evidence, as I referred to in my testimony, from our national service offices listing—at this particular time, anyway, in our compilation of that data—at least 40 veterans who have been denied services.

Senator MURKOWSKI. Are they category A veterans?

Mr. GORMAN. Some of them are. We can isolate those, ranging all the way from service-connected paraplegics down to veterans who are service-connected with specific conditions.

Senator **Murkowski**. Do you have any explanation as to why they are being denied care?

Mr. **Gorman**. The reasons cited by our NSOs are varied, and I think a lot of this is what we had to say before. As far as surgical care, they are simply not doing what the VA would term "elective surgery." To a veteran who is in pain, has discomfort, has limitation of motion, can't move his shoulder, it is not "elective surgery" in his mind; and they are going elsewhere for it.

We do have the cases; we do have the documentation, and that has been submitted.

Senator **Murkowski**. Fine. Do you have that material available for the committee?

Mr. **Gorman**. Yes, we do. It has been submitted to the committee.

Senator **Murkowski**. It has been submitted?

Mr. **Gorman**. Yes, sir.

Senator **Murkowski**. At this hearing?

Mr. **Gorman**. Prior to the hearing.

Senator **Murkowski**. Prior to the hearing? Is this available? Oh, all right. We don't have it available now, but you will make it available?

Mr. **Steinberg**. We are making copies of it.

Senator **Murkowski**. All right. We intend to make it available to the VA for comments. It would be my request that the VA attempt to respond to it as expeditiously as possible.

Mr. **Cullinan**. Senator Murkowski?

Senator **Murkowski**. Yes?

Mr. **Cullinan**. I would add to that that, at Wednesday's hearing before the House Veterans' Affairs Committee, testimony from several directors of VA medical centers indicated that they had denied category A patients care. When queried on this, they indicated that, if they discovered that a veteran was perhaps entitled to health care elsewhere—if he had insurance—that they would do that for the sake of timeliness or for the sake of——

Senator **Murkowski**. Is that reasonable if the veteran has other health insurance, that he shouldn't pursue it? He is paying for it.

Mr. **Cullinan**. If he does have insurance, there is a method for the VA to collect that.

Senator **Murkowski**. That is correct; there is.

Mr. **Cullinan**. But we believe that the VA is the primary provider—especially for category A veterans—and guarantor of health care.

Senator **Murkowski**. We agree.

Mr. **Cullinan**. I would speak to the issue of operating beds. I notice the chart is still up behind there. We believe that, for one thing, they have been able to accommodate a greater number of veterans while utilizing fewer beds because of efficiencies and because of an increased utilization of outpatient care.

We question, however, if there are not times when veterans would be better served by being provided inpatient care, rather than outpatient care. We believe there may be a tendency now, out there among the VA directors, to encourage outpatient care because it is a little bit cheaper.

Senator MURKOWSKI. I agree. That is kind of a tough one to call because you folks are not the health-care professionals nor are we in that area of making that determination of just how long a veteran should have in-house care. I assume that the humanitarian as well as the professional capability of the VA system internally would mandate what is in the best interests of the veterans. If we have a situation contrary to that, obviously we have some significant problems. I don't think that is the case, and I don't think you would agree that it was.

Mr. CULLINAN. We believe that, too, but we also believe that there is a kind of equilibrium which is established between fiscal pressure and humanitarian urges and responsibilities. If the fiscal pressure increases, that equilibrium is going to shift somewhat.

Senator MURKOWSKI. I agree with that; but by the same token, let's be realistic. We have a balance; you folks have a job to do which is to represent the best interests of the veterans. So, you promote veterans' interests; and the VA has the job of responding with the tools that they have. And we have the oversight responsibility of trying to fund a system based on never being able to adequately repay the obligation—that is a given. That is just a fact. You will never be able to repay that obligation adequately.

So, it is a constant compromise, just like the governmental function; more is going to be desired than is going to be provided, unfortunately, to the veterans as well. So, this balance of your input coupled with the VA's responsibility of trying to meet their professional requirements is what this is all about and the value of this hearing.

Any others care to comment on the points that I have mentioned?

Mr. SOMMER. Yes, Senator. The American Legion is aware of, in some cases, category A veterans being denied care in the past. Because of the number of complaints that we have received recently, we are going to do another survey.

Our last survey was completed about a year ago. So, we are going to again contact our people who work with the hospitalized veterans throughout the medical care system.

The second thing I would like to mention is that you alluded to the fact that we have mentioned complaints and a lot of our testimony is based upon the fact that we have gotten complaints from the——

Senator MURKOWSKI. I would expect you to get lots of complaints—that is your job.

Mr. SOMMER. Thats right. However, I would like to point out, as is mentioned in our full statement, that a lot of the material we receive is from a full-time staff of American Legion field representatives that make site visits to VA medical centers. They spend a week at each facility. They do a very thorough survey. They come back and write a very comprehensive report on their findings; and we provide our recommendations to the chief medical director, along with a copy of the report. And we also furnish this committee copies of the report.

So, a lot of our information is not just coming from complaints; it is coming from surveys that we are conducting on, on an ongoing basis.

Senator **Murkowski**. Anyone else care to comment?

Mr. **Sherwood**. Yes, I would comment on this. Clearly, the issue of the denial of care to category A veterans is of tantamount importance. But as a clinical person, I think that the thing that ultimately has to count is the quality of the product that we deliver, regardless what the category of the veteran is.

If we accept the responsibility of a veteran into a VA facility for VA care, certainly VA is interested—no matter who that veteran is—that that center meet the responsibility of delivering a good product of quality.

With respect to the chart, basically it is saying that, in terms of 1977 dollars, the VA is operating with a budget of $5 billion and that for inflation or whatever else, in terms of today's dollars, it is a $10 billion system. Again, here what I think the chart at least signifies to me is that even in terms of real dollars, given the kinds of complexities in the delivery of the health-care system, given the size of the system, and the kinds of things that the system is being asked to do, to say nothing of the technology of the actual delivery, we will have to face that this is a more expensive system and that, as a more expensive system, it is integrated in many ways into the larger expensive health-care system of this country.

Folks clearly recognize that. Ten percent or 11 percent of the GNP for health care is a big number. The VA may have to finally, as an organization delivering a product if the quality of care is its primary issue, face the reality of those costs. If it is unable to, then integrate with a larger system, developing a new system that allows the veteran to get the quality of care that every other American citizen should get in the country.

Finally, with respect to the nursing shortage, it is not adequate to say that there is a nursing shortage all over the country. In the sense that it begs the question of responsibility. The agency has to do everything it can to correct the nursing shortage issue within the Veterans' Administration. There is a real shortage in the country, but there is also a real shortage of nurses in the VA. It is having a dramatic—as you will hear later on—impact on the VA system.

There are probably many more things that we can do to alleviate that.

Senator **Murkowski**. Mr. Mansfield?

Mr. **Mansfield**. Yes, sir. No 1, we do have examples of category A veterans being denied care. As I explained in my testimony, I think denial of care is more than just saying don't come in here; it is sometimes the way you are treated or the length of time it takes to get care.

In regard to the dollars, I think the VA has done an excellent job in increasing productivity. I think they have done an excellent job in shifting to less cost-intensive ways of doing business; and I think they need to be commended for that.

As I said, though, I think they have reached the point where they can't stretch things too much further because the rubber band is going to snap.

On the bed levels, we have all talked about the phantom bed problem for a number of years. The problem there is that you have beds there, but there is nobody in them because there is no staff to take care of somebody who is going to be in that bed because they are taking the staff and robbing it to put it some place else.

I would also like to say that what we are trying to do here is provide constructive criticism; and I know that General Turnage has indicated before that he seems to feel any criticism is the denial of the complete system; and we are not trying to do that. We think they are doing a good job under adverse conditions. And like I said, I think the people at the medical centers—the directors, the nurses, the people down there—are the ones who have been forced to carry this load. And I think that it is time that the leadership in Washington starts helping them out.

And the last thing I would like to say, Senator, is that it continues to amaze me that we hear about somebody at OMB—I am getting the impression that a GS-14 at OMB—is running a $10 billion system. I think we all have to acknowledge that we have our parts to play in this, that we have a problem, that we have to work together. We have to solve the problems. Veterans are due care, and they should get it.

Senator MURKOWSKI. Anyone else care to comment?

[No response.]

Senator MURKOWSKI. You know, it is very difficult to try and reasonably reflect on the adequacy of one to judge quality of care. I certainly wouldn't attempt to do it. You folks get the information, but I think you yourselves recognize the limitations. It really takes a professional; and that is, of course, the responsibility of the head of the medical branch of the VA to make a determination based on his or her professional commitment to quality care. And if the care is of a declining nature, they must take the necessary action.

I am not satisfied—although we have not heard from the VA at this time—that there is likely to be an admission that the quality of veterans' care is beyond the realm of reasonable quality care, which means different things to different people. Obviously, when you go to the hospital and receive medical treatment, you want the highest quality available. You are entitled to it; you should have it.

The question of how that care is delivered, the adequacy, and the responsibility are all very real questions. But how that is measured is something that is a little difficult to judge. But I think it is fair to say that the VA internally is a very professional organization; the physicians have received professional training at great cost, in many cases to the Government for advanced studies, and their commitment is in the highest order of the profession of medicine.

I think we have to make those assumptions. As you bring in this information, which is valuable to this committee, from your membership, one has to draw, I think, a conclusion perhaps that there are delays. The delays, in some cases, seem to be unreasonable, but the delays themselves are not necessarily the same as denial of care. I think you generally agree with that.

I am very pleased that some of you have seen fit to document specific cases where there has been denial of care for category A veterans because we intend to pass that information on to the VA. I would ask that be made available to the committee, not only the cases that you bring up before the committee but the response of the VA, so we can address these issues in an expeditious manner.

Chairman Cranston. That will be made available, and we do intend to give the VA an opportunity to review them in order to comment on each allegation.

Senator Murkowski. I appreciate that, Mr. Chairman.

Finally, I think the chairman will recall that this committee authorized a bonus for VA registered nurses; I think it was $16,000 to nurses who commit to a 4-year length of service in the VA.

I am not sure that program has been instituted as yet, but I did want to respond to Mr. Sherwood to indicate that the VA is cognizant, and this committee is cognizant of the nursing shortage. This committee has authorized this bonus in recognition of the realities associated with nursing in the VA, and I would beg the question. I think that nurses professionally are tremendously underpaid; and as a consequence, unless that matter is redirected in the entire Nation's health-care system, we are going to suffer an ever-increasing nursing shortage.

I have some other questions, Mr. Chairman, but in the interest of time, I would submit them individually to the representatives of the various service organizations.

Again, I would ask and urge that any of you who have information relative to category A veterans not receiving treatment—I am not really interested in delays because we are all subject to delays. Those of us who have been in the service have had plenty of experience with delays. But the facts of not receiving care are the information we are requesting. Thank you, Mr. Chairman.

Chairman Cranston. I would like to point out on the matter of the bonuses that that is not yet an operating program. It is going to cost something like $50 million; so we can't depend on it until we have the money in place, if we get the money in place. Arlen?

Senator Specter. Yes, thank you very much, Mr. Chairman. I have found the testimony so far to be very helpful. I regret that I am going to have to leave shortly before 10 a.m.—in just a few minutes—because of other commitments; but I will review the transcript.

I note that Administrator Turnage is present to hear all the complaints and will be able to respond to them; and I think that is a good procedure. I compliment the Chair for arranging it and Administrator Turnage for approaching it in that manner and staying through.

I would like to find out what your impressions are—the witnesses—as to the response of the Veterans' Administration once specific problems are called to your attention. I believe that is really the essence of evaluating a system; and I know it is one thing when Senator Thurmond calls or Senator Cranston calls or Senator Murkowski calls or even I call, contrasted with what happens when calls are made by a veteran specifically or veterans' organizations.

Mr. Mansfield, I see you with a thought in mind. What happens when you make specific complaints?

Mr. Mansfield. I think generally they are very responsive; and our national service officers, our chapter representatives, in working with the local VAMCs, take care of it. One thing I would point out—and I heard it earlier—and the reason that I jumped in here is that you can't expect a system with 172 hospitals and that many people, though, to be responding to General Turnage's call down the pike to make it run.

You have to have the resources, the medical center directors, and the people at the local level so that they can do it, and you are not getting calls from Vermont Avenue from the General to make the system work.

Senator SPECTER. You don't think he can review every complaint personally?

Mr. MANSFIELD. I am sure he makes an effort to do it. There is no doubt in my mind that he has a large staff working with him——

Senator SPECTER. I don't think even he could make an effort of——

Mr. MANSFIELD. The point I am making is that you can't expect the Administrator of the VA to be handling individual cases, to be an ombudsman for individual veterans.

Senator SPECTER. I agree with you, Mr. Mansfield. That is why I am asking you. You find that, when your organization brings specific complaints to the attention of the VA personnel on the spot, they are responding?

Mr. MANSFIELD. Yes. I would like to reinforce, too, again—and I have said it twice before—and that is that we have to give credit to the people out there in the field: the medical center directors, the nurses, the doctors, and all these folks who are working under these adverse conditions. They are trying as hard as they can to get the job done; we know that.

Senator SPECTER. All right. Now, you have a significant position with the Paralyzed Veterans of America. What is your view as to what happens if the veteran himself complains? Do you think he gets adequate attention?

Mr. MANSFIELD. I think it depends on it, sir. I can start going into anecdotal information, which apparently nobody wants to hear around here; but I have had my own instances where I have been in a VA medical center, and this goes back a few years. But I have had to call my Congressman to get some prosthetic stuff released.

Senator SPECTER. But you got it done?

Mr. MANSFIELD. My Congressman got it done, but the point I am making here is that you have to get the resources. Again, it was a resource problem. You have to get the resource; the resources have to be in place.

I think, as I said, generally the service organizations are there to make the system work.

Senator SPECTER. So, your view is that, if you get into it as a key official from the Paralyzed Veterans of America, it gets done; but if an individual veteran makes a complaint, it is hard for him to get response because of insufficient resources? Is that the nub of your testimony?

Mr. MANSFIELD. I think that is the reason you have heard all of us here saying that we are getting more and more complaints from the individuals or our service officers out there because they are not getting the response they want. So, they are going to the service program people to get more help. I think that is what is being indicated here.

Senator **Specter**. Mr. Sherwood, what has your experience been? When matters come to your attention and you make a complaint, are they corrected generally?

Mr. **Sherwood**. Yes. What I find is that indeed that is the case. A lot of matters come to my attention, and I have a good working relationship with the Veterans' Administration and the staff of the medical centers. So, when I make a call to try to get the issue addressed for veterans, it gets done.

But in a sense, that is not the problem. The problem is that it is becoming a system of the privileged. For those who have the connections, if you will, either through service organizations or a Congressman or other folks who can make those calls directly to the General or to other key people in the Veterans' Administration, they can of course get the attention that, in fact, they deserve.

But in point of fact, there are many, many veterans out there who do not have those kinds of connections, do not have the wherewithal it takes to make complaints and who bear their pain very, very quietly.

The medical centers and their staffs, given the resources and the conditions that they must operate under, simply are constantly putting out fires. So, there are veterans who absolutely get missed in that situation. That, to me, is the greater concern.

There is no issue with respect to the connections in terms of those who are in key positions who can make a direct contact and get a particular veteran served.

Senator **Specter**. You don't have to be in a key position to get a U.S. Senator to help you. If people come to one of my offices or write me a letter, we have a standard response to make an inquiry. It does not require any unique standing.

Mr. **Sherwood**. The "key position" is a term of perception.

Senator **Specter**. It may be that some people do not know that they ought to write their House Member or their Senator.

Mr. **Sherwood**. We tell them.

Senator **Specter**. We do other things. I make it a practice to send notices out on open house/town meetings all around the State; and there are frequently concerns raised about the Veterans' Administration at those meetings, but I would say no more so proportionately than Black Lung or less so than Social Security—a fair number.

But what I am trying to get from you is a sense of how big the problem is. And I quite agree with you that, if there are many out there who don't complain to you or to us, they may not be getting the service. And the volume of your complaints and the increase is evidentiary of need for greater service.

Mr. Gorman, what do you find?

Mr. **Gorman**. Senator Specter, I think that when we get complaints, the vast majority of VA employees—including Dr. Gronvall and his staff over at the Central Office—are dedicated to giving the veteran the proper medical care he needs and he deserves.

In that respect, I think the VA is responsive to our inquiries when we do have a problem come up and we complain to them. I would answer the question in another vein also, though; and that is that you have heard all of us talk somewhat about problems in prosthetics. For 7-plus years, the DAV, joined by the PVA and the

VFW and The American Legion, have been constantly talking and discussing and doing battle with the Veterans' Administration over the issue of their prosthetics program.

Right now, the main topic that we seem to be concerned with, and vitally concerned with, and that we cannot seem to get resolution to—and this has been brought up to the Administrator, to the Chief of Staff, to Dr. Gronvall, and to many, many people in different capacities within the Department of Medicine and Surgery—and that is the issue of funding. And that is not only the issue of more dollars, which I believe they do need, but also the issue of the method they use to distribute those dollars to the field. This has been an ongoing problem.

Senator SPECTER. How long has this problem persisted?

Mr. GORMAN. We, I think, initiated this problem in 1981 with a hearing on the House side. It has been constant since then, with peaks and valleys in the activity.

Senator SPECTER. What is the essence of it—just more money?

Mr. GORMAN. No, no, to the contrary. I think money is an important part of it, but I think it is the method that the Central Office uses to distribute those funds to the field stations for use in prosthetics; and they cannot seem, to our satisfaction, to give us any kind of a response or any substantial indication they are moving in a direction to remedy the problem.

It is real hard to have a service-connected disabled veteran who has lost his leg in combat come to us and say: I can't get a prosthetic device from the Veterans' Administration for 2 or 3 more months, until the next fiscal quarter starts. We don't have an adequate response to that kind of a question.

Senator SPECTER. I would hope this will come up when Administrator Turnage testifies. Mr. Turnage, if we might have your attention for just one moment? Mr. Gorman is raising a point about the prosthetic issue. I am not sure that I will be able to be here when you testify, but I would appreciate your directing a response to that; and I will follow up on it. I am sure other members of the committee will as well.

Mr. Turnage. Sir, that is just what we are talking to the doctor about.

[Subsequently, the Veterans' Administration furnished the information which appears on p. 759.]

Senator SPECTER. Getting the answer all set? Fine.

Mr. GORMAN. I hope the conversation doesn't go on as long as ours has.

Senator SPECTER. I don't think the chairman will permit that. Mr. Cullinan, what do you find on your specific complaints? And how are they responded to?

Mr. CULLINAN. Senator Specter, our assessment essentially confirms what my colleagues have already said. If we put in a complaint, the VA will be very responsive more times than not. For that matter, we believe that if a veteran himself is persistent and stays with it, his problem will eventually be appropriately answered.

Our fear is for the veteran who is perhaps not so well versed in the workings of the VA or the bureaucracy or Government in general, who doesn't really know what to do. We think that is the veteran who is falling through the cracks.

Senator SPECTER. Mr. Walsh, do you have anything to add to what has been testified to on this point?

Mr. WALSH. No, sir. Mr. Sommer handles that, and I think he can respond.

Senator SPECTER. Mr. Sommer, you are the cleanup batter.

Mr. SOMMER. Senator Specter, thank you. We have found that the employees in the individual medical centers have been very cooperative when we contact them relative to a problem. I think it is fair to say that they have been as responsive as they possibly can be within the parameters of the resources that are available.

Now, with respect to the question that you raised a moment ago about the extent, as I mentioned previously, we are going to do a survey of our individuals who are involved in the Veterans' Affairs and Rehabilitation Program and other organizational officials to determine just exactly what we can find about the extent of the problems that are existing within the system; and we will be glad to furnish those findings to this committee.

Senator SPECTER. Thank you very much for your responses. Perhaps one message which should go out from these hearings is to the veterans themselves; when they have a problem and are dissatisfied, they ought to express it. And they ought to express it to the veterans' service organizations or to their U.S. Senator or U.S. Representative because I know that all of us seek to be diligent in relaying those messages.

It is unfortunate that the squeaky wheel gets the oil, but that is the nature of life. We want to correct it so that the silent people can get care as well. But I am glad at least to hear that when those who are dissatisfied come forward and speak up, there is a good record on service, once the complaints are made known and the problems are identified. Thank you very much, Mr. Chairman.

Chairman CRANSTON. Thank you very much. I think that completes the testimony of this panel. We thank you all very, very much for your being with us and for your helpful testimony.

We would now like to welcome and hear from representatives of the VA field staffs. Would those witnesses please come to the table?

This panel includes the directors of four VA medical centers: Mr. James Farsetta, Director, Brooklyn VA Medical Center; Mr. James Goff, Director, Boise VA Medical Center; Mr. Wayne Hawkins, Director, Dallas VA Medical Center; and Mr. Terrence Johnson, Director, Indianapolis VA Medical Center.

We would also like the following people to be at the witness table: Dr. A. Wendell Musser, Chief of Staff, Atlanta VA Medical Center; Dr. Thomas Newcomb, Chief of Staff, Durham VA Medical Center; Dr. Elizabeth Rogers, Chief of Staff, Baltimore VA Medical Center; Ms. Rowena Bishop, Chief Nurse, West Los Angeles VA Medical Center; and Ms. Carol Coulter, Chief Nurse, Boston VA Medical Center.

Good morning to you and welcome to Washington. We appreciate your coming, some of you from long distances, including from California. I do want to extend a special welcome to Ms. Rowena

Bishop. You previously appeared before our committee, and I am pleased to see you again.

If you would all rise, I would now like to administer the oath.

[Whereupon, the witnesses were duly sworn.]

Chairman CRANSTON. Thank you very much.

Senator MURKOWSKI. Mr. Chairman?

Chairman CRANSTON. Yes?

Senator MURKOWSKI. Why are we swearing in witnesses? Is this a new procedure? This is not a normal procedure of the committee.

Chairman CRANSTON. The basic reason is that we have done this from time to time for various reasons. We wanted the people who are here from the field to feel that they are, due to that oath, under an obligation to level with us in every way. And it will relieve them of pressures that they might otherwise be under.

Senator MURKOWSKI. I guess it will be a pattern from now on in the committee then?

Chairman CRANSTON. Not necessarily. We will see. I believe that none of you have prepared statements. You have not been asked to present direct testimony, but only to answer questions. So, we will begin in that way.

Generally, my questions will be directed to all of you or each of you. Thanks again to many of you for traveling so far to be with us. We appreciate the vital work that you are all doing. Each of you has had extensive experience in the VA system.

Would you please tell the committee the number of years of experience you have had in the system and where you have served? Tell us generally, in conclusory terms—we will get to specifics shortly—how you would characterize the current funding and resources situation, both at your facility and nationwide.

I have this morning called the current situation a crisis. Do you agree with that characterization? And if not, how would you characterize it? And then tell us the two or three greatest problems now and anticipated for next year at your facility?

If you would start at the right end and state your name, current position, experience in the system, your characterization of the present situation at your facility and nationwide—is it a crisis or not—and give examples of the worst problems? That is a rather long list; please do it very briefly.

STATEMENT OF JAMES FARSETTA, DIRECTOR, BROOKLYN VA MEDICAL CENTER

Mr. FARSETTA. My name is Jim Farsetta. I am the Director of the Brooklyn VA Medical Center. I have been the Director of Brooklyn since October of 1982. Prior to that, I was the Associate Director at the VA Medical Center in Philadelphia. Prior to that, I was Assistant Director Trainee at the VA Medical Center in Houston, TX. And prior to that, I was Staff Assistant to the Chief of Staff at the Manhattan VA Medical Center.

Chairman CRANSTON. What is your total number of years in the system?

Mr. FARSETTA. Nineteen years.

Chairman CRANSTON. Thank you.

Mr. **Farsetta**. In addition to being the Director of the Brooklyn VA Medical Center, I am also the Chairman of the Regional Planning Board, and I am Medical District Director.

Although I will be talking about the shortages that I will be facing at Brooklyn, I have been in contact with the 23 medical directors in the Northeast region, in addition to 13 other VA medical center directors who have contacted me because I would be here today.

What I am going to be telling you today I think is a crisis; and although I think it varies at different VA medical centers, I think that the term "crisis" is an appropriate term. In Brooklyn so far, I have not turned away any veterans, but it has cost us. Our inventories are way down; we have increased the number of restricted medications. We have gone without the equipment we have needed. I have used every management tool that has been available to me so I could maintain an adequate quality of care, and I think I have done so; but I think I have exhausted every avenue that I have available to me.

Next year at Brooklyn, I will be dealing with—under the best case scenario—a $6 million budgetary shortfall; under the worst case scenario, probably a $10 million budgetary shortfall. How I am going to be dealing with that shortfall is partially dependent upon what goes on at this hearing today, partially dependent upon the direction that the Department of Medicine and Surgery gives us.

You alluded to a report that was done, an internal document that was generated, by the Veterans' Administration. Many of us have participated in the development of that document, and many of us are waiting for what action the Chief Medical Director will be directing us to take.

In addition to that, some of us are looking for ways to bridge getting through fiscal year 1989 so we can deal with the fiscal year 1990 budget.

The problem that I am confronted with is: Basically, how do I deal with a $6 million budgetary shortfall without authority to do items such as RIFfing employees, furloughing employees, and denying care to people who are entitled to medical care? If you want specific examples, I feel next year that I need to take every single nonrecurring account that is available to me—be it equipment, be it maintenance and repair, be it community nursing home—and divert those funds to deal with recurring shortfalls.

That is going to have an enormous impact on my ability to buy equipment. Currently, I am about $4.4 million short of what I need to provide equipment for the patients at my institution. This year, my budget has allocated about $1.2 million for equipment, but I cannot use that money for equipment. I have to use those dollars for recurring shortfalls.

If I have to divert my community nursing home money to pay for recurring shortfalls, then that means that patients stay in the hospital a little bit longer than they should be staying in the hospital; and that leads to a more inefficient system of operation.

I think the issue of using maintenance repair dollars for recurring shortfalls is also a poor strategy. I happen to come from a city—New York City—where for probably 15 or 20 years, they didn't put any dollars into maintenance and repair; and one needs only to have looked at the Williamsburg bridge to realize what a shortsighted philosophy that is and what a poor management practice that is.

It is my feeling that one of two things needs to happen. Either we need additional dollars to do what we have to do, or we need the authority to reduce services to veterans. And in the reduction of the services to veterans, I am talking systemwide now. If one looks at the Bell report, I think the issue of mission changes and facility closures needs to be considered.

That will conclude my statement.

Chairman **Cranston**. Thank you very, very much. Mr. Goff?

Senator **Murkowski**. I wonder if we could have each person indicate what his budget is?

Chairman **Cranston**. Certainly.

Senator **Murkowski**. What is your budget, sir?

Mr. **Farsetta**. My overall budget is $110 million.

Senator **Murkowski**. Thank you.

Chairman **Cranston**. Mr. Goff?

STATEMENT OF JAMES GOFF, DIRECTOR, BOISE VA MEDICAL CENTER

Mr. **Goff**. Thank you, Mr. Chairman. I am Jim Goff. I am the Director at the Boise VA Medical Center. I have 25 years with the Veterans' Administration. I am a third generation VA brat; my grandfather was a director and my father was an engineer. I have been with the VA all my life basically.

I have lost track of how many places I have worked: Chicago, Indianapolis, Montana, twice in California, Washington, DC, Cleveland, Boise, Spokane, and a few others. The total budget for the Boise VA medical center is about $28 million.

I was glad to hear Senator Murkowski say that not all VA medical centers are the same. The problems are different in different places. Boise is a relatively small VA medical center by comparison with most, and we are also a fairly remote VA medical center. We are the only one in the State of Idaho; it is 400 to 500 miles to the nearest VA medical center that does any more than we do.

In our particular environment, veterans have limited alternatives. We are a largely agricultural economy. There is not a lot of health insurance. A lot of people are category C veterans because they own a farm; but they don't necessarily have access to health care because they are category C, and they are still medically indigent.

So, we in Boise have been a safety net for these people. We don't have a Cook County or a San Francisco General for them to go to if we can't treat them. We are a kind of last frontier in Boise; we have a strong work ethic. There has always been a feeling that, if you worked hard and did the right thing, everything would work out.

Under the resource allocation methodology, we were naive enough perhaps to believe that that would be the case. Every single year of the resource allocation methodology, Boise VA Medical Center has been what we term a "winner," uncapped to the tune of about $1 million. However, we haven't received that money; so we started with an eroded base.

I went back and calculated our budget need for fiscal year 1989 three different ways. I started in 1982. I applied the medical Consumer Price Index to our 1982 budget, which itself was short, and I came up with a $2.3 million deficit for 1989. I used the conventional mechanism of looking at workloads and staffing levels and projecting the needs, and I came up with a $2.7 million deficit.

I went through and itemized the areas where we have been taxed or shorted in the budget or things have been withdrawn for productivity improvements and that kind of stuff, and I came up with $2.5 million needed at Boise. So, any way I cut it, we are looking at about a $2.5 million deficit next year.

Now, in fiscal year 1988, we are going to make it; but we are only making it the way everybody else is—by using a lot of our nonrecurring resources to support the hospital. We have diverted over $600,000 in fiscal year 1988, and project to divert over $1 million of nonrecurring resources in 1989.

We are one of the management efficiency pilot programs. There are five VA medical centers that were chosen to be given flexibility in management, to move money around and make the best use of resources. This has helped us. We at least have incentives now to control contract hospitalization, fee bases, fee medical and fee dental accounts, and some of those accounts that most VA medical center directors really don't have any incentive to control because, if you need more money, you get more money.

Actually, if you can divert your expenses into those accounts, you can save your hospital budget a little bit. So, we have a little different incentive now. We are able to try to use that money as wisely as possible, and we are trying to do that; and it has helped us get through this year.

Much of what we have done has been detrimental—the diversion of maintenance and repair money, the diversion of equipment money. The question has been raised about category A veterans being denied care. We are not denying them care, but if we don't offer the service in Boise—they don't get it and I will give you a good example—lens implants, which is an outpatient procedure, we don't do.

So, we say you will have to go to the nearest VA medical center that does that, and you have to get there on your own because we are not going to give you the travel money to get there because we don't have to. In essence, sending patients from Boise to another VA medical center is distance-wise the same as if you referred patients from Washington, D.C. to Boston, Buffalo, Cleveland, or Detroit. Those are the kinds of distances that we are talking about sending patients out West.

Chairman CRANSTON. Do you consider the situation a crisis?

Mr. GOFF. Yes, sir, I do. I believe that we are going to seriously impact our ability to accomplish our mission if we don't have improvements in our budget for next year.

Chairman CRANSTON. You consider that to be the situation both in Boise and, as far as you know, from other information you have received nationwide?

Mr. GOFF. From talking to my peers around the country, yes, sir.

Chairman **Cranston**. If we may now move on to Mr. Hawkins? And thank you, Mr. Goff.

STATEMENT OF WAYNE HAWKINS, DIRECTOR, DALLAS VA MEDICAL CENTER

Mr. **Hawkins**. Thank you, Mr. Chairman. I am Wayne Hawkins. I have 30 years of experience in the VA system. I have served at Mountain Home, TN; Asheville, NC; Biloxi, MS; Waco, TX; Minneapolis, MN; Spokane, WA; Portland, OR; Nashville, TN; and am presently Director at Dallas. My budget runs approximately $100 million.

As far as the question you raised, relating to adequate funding, I find myself or the Dallas Medical Center as having an approximate $5 million deficit for fiscal year 1989, based on what I know at this point. As far as I am concerned, I think we have over the years had a cumulative effect of a negative budget, which has caused us to get into the situation that we are in; and I would classify going into the 1989 year as being a crisis.

Some of the greatest problems that we have are the accumulation of the cuts we have had over the years. The 1 percent productivity cut for 4 years in a row represents over 100 employees at my facility. The inventory problem is a major crisis at my facility. I am drawing down my inventories critically low this year, and I am delaying care. Timeliness is not good, and my medical staff tells me that quality is eroding.

Adequate equipment, nonrecurring maintenance are critical items in terms of being able to attract key physicians and nurses. We have people who have left our facility because the equipment in the facility or maintenance in the facility is not up to the standards that match modern technology.

We are deeply concerned over what will happen in 1989 if we don't take some kind of action to either reduce workload or to give us more flexibility to manage the resources that we have. We presently cannot get the job done with the way things are right now, and I think we have been given an impossible task in 1989 unless some changes are made.

Senator **Murkowski**. I wonder, Mr. Chairman, if Mr. Hawkins could indicate what his budget is?

Mr. **Hawkins**. $100 million, sir.

Chairman **Cranston**. Thank you very much. Mr. Johnson?

STATEMENT OF TERRENCE JOHNSON, DIRECTOR, INDIANAPOLIS VA MEDICAL CENTER

Mr. **Johnson**. My name is Terry Johnson. I am the Director at Indianapolis; I have been there as Director since 1981. It is my eighth VA assignment, having been in assignments at Memphis, TN as Associate Director; Birmingham, AL as Associate Director; and a number of other facilities prior to that time.

Chairman **Cranston**. How many years have you been in the system?

Mr. **Johnson**. Twenty-three years, Mr. Chairman. Our budget in Indianapolis is about $65 million. We have active programs in all four VA mission areas: research, education, clinical care, as well as

DOD sharing. We are the tertiary care referral hospital for our medical district, the only tertiary care hospital in our medical district.

It is a relatively compact district, and we have daily shuttles that run among the district hospitals. We also have a very close working relationship among the district hospitals in delivering services based on our district mission.

Last year, we set our alltime record in terms of inpatients treated. This year looks like it will be very similar, although we will do that with less patient beds in service. Our outpatient visits have been growing at a fairly significant rate—probably about 10 percent per year.

About one out of five veterans that apply for admission have never been to the VA before. So, there is a large number of new patients coming to us.

We have not denied care to any category of veteran; about 96.3 percent of our veterans are in the traditional category A.

Fiscal year 1988 has been the most difficult year that we have been through. We as a district decided at the beginning of the year that we would set aside our nonrecurring resources to augment our budget and try to maintain services in all categories of care. We also all committed ourselves to continued high quality of care for the veteran patient.

For fiscal year 1988, we had a $3.9 million shortfall, and we covered this by redirecting nonrecurring M&R dollars, as well as equipment dollars. In a rather remarkable effort, but because of our close district working relationship, the other district hospitals contributed $2 million in nonrecurring equipment and project funds for reprogramming toward our shortfall at Indianapolis.

We also used about 75 percent of our equipment money in Indianapolis and 100 percent of our nonrecurring M&R money to support the shortage for 1988. Indianapolis has been a cost-effective facility. We have been a RAM gainer for fiscal years 1987, 1988, and 1989; uncapped gains of $6.4 million; and about $1.88 million uncapped.

We also are one of the five—as Boise is—of the management efficiency pilot hospitals. As a teaching hospital, we have been committed to high quality, and we have been making every effort to meet the challenge of keeping up with the technology demanded of a tertiary care hospital and the current medical therapies.

The cumulative effect of the various reductions that we have had for workload and other line item reductions—productivity and so on—have reduced us by about $3 million in our recurring base over these recent years. We also have had an underfunding of inflation, probably in the neighborhood of about $1 million per year, which has a recurring impact as well.

We now have reached this critical point in 1988 where there are no longer other pots of money, like equipment and project funds, to tap to meet the kinds of shortages we are predicting for fiscal year 1989. We don't feel we can continue in good management judgment to postpone equipment purchases. Our replacement equipment accounts have a backlog of over $6 million at this time. We also have a large backlog in nonrecurring projects.

As a result we are very concerned about heading into fiscal year 1989.

Chairman **Cranston**. I don't believe you characterized the matter as to whether you believe it is a crisis or not.

Mr. **Johnson**. Yes, sir, I do.

Chairman **Cranston**. You do? Thank you very much. Dr. Musser?

STATEMENT OF DR. A. WENDELL MUSSER, CHIEF OF STAFF, ATLANTA VA MEDICAL CENTER

Dr. **Musser**. Thank you, Mr. Chairman. In respect to the Chief Medical Director and the Administrator, this is a crisis; and it is one that has grown over a number of years. We used to address it in the early days when I was Assistant Chief Medical Director for Planning and Evaluation as an equation of needs versus desires.

Chairman **Cranston**. How long have you been in the VA?

Dr. **Musser**. Twenty-six years; 7½ years as a service chief, 3½ years as an ACMD at VA Central Office, and 15 years as Chief of Staff.

Because it was an equation of needs versus desires versus resources, we began to pare the care package down over a great number of years as the resources began to shrink. We have now eroded deeply into our ability to equate these resources to bona fide, legitimate, legislatively mandated needs; and that is where we are right now.

We are aware of Senator Murkowski's comments relative to the overall health-care dollar and the national economy, and in our best efforts, we are attempting to deal in some realistic fashion with that. But I think the Congress and this august body has to understand that we have reached the point where something has got to give. We have wrung the last drop of moisture out of the system, and we are in a crisis.

The budget at Atlanta is approximately $69 million; we figure the shortfall for fiscal year 1989 will be $5 million. I have given for the record responses to several detailed questions in relation to redistribution of dollars, taking them out of maintenance and repair and equipment funds.

During my days in Washington, I had the opportunity to direct the Hospital Construction Service and am acutely aware that one way to completely erode the firm undergirding of any organization that depends upon physical structures is to not let them repair them and not let them replace them adequately.

Our big problem is the $5 million. Our other problems relate to space in Atlanta. I visited Atlanta when I was ACMD in 1971 and found out that here was a relatively new hospital that was retarded in program development and had not even begun to reach for its potential. When I took over the Chief of Staff job there in 1980, I found out that very little had occurred in the interim years.

When you look at these graphs that we were shown around here, those graphs would be more useful if everybody had started out equal; but everybody did not start out equal in 1977. And therefore, one must be very, very careful in interpreting those graphs.

We live in a hospital that is now 22 years old, and every piece of equipment in it is about ready to dissolve. So, that is a problem.

So, space, equipment, M&R, and a budget shortfall are the problems that we face locally; and it is our impression at least—not based on any data available to us—that this is a problem that is spread throughout our system. Thank you, sir.

Chairman CRANSTON. Thank you very, very much. Dr. Newcomb?

STATEMENT OF DR. THOMAS NEWCOMB, CHIEF OF STAFF, DURHAM VA MEDICAL CENTER

Dr. NEWCOMB. I am Tom Newcomb. I would like to date the onset of my service VA when I was 17, serving as a corpsman in the local Naval hospital. As a result of this, my entire education, Senator Murkowski, was paid for by a combination of the GI Bill of Rights and scholarships. So, I owe a great deal to this country as far as my personal life has been concerned.

I have subsequently had 26 years with the Veterans' Administration, ranging in positions from resident to Assistant Chief Medical Director—currently, I am a Chief of Staff—serving in five hospitals and in Central Office's ACMD for Research and Development for 7 years under Dr. Musser and Dr. Chase.

I can't resist using a medical analogy on a couple of points. The first has to do with the comments of my esteemed colleague to the right, and it reminds me of a dermatologist who was presenting a case at grand rounds. He went into a considerable discussion of this, whereupon an internist sitting in the front row got up and said: Well, Doctor, I share your concerns but not your vocabulary.

All in a crisis; crisis is a medical term. It goes back to the days of pneumonia when the patient's fever got higher, he got sicker; and if the immune system of the body was able to turn the disease around, there was a sudden change for the better. If there was no change for the better, that patient died. If there was a change for the better, he got rapidly well in the course of the next day or so.

This is contrasted to the resolution of other types of pneumonia by lysis, which is a slow, day-to-day gradually getting better. In that sense of the word then, this is not a crisis. This is not a life or death situation for the Veterans' Administration.

We have a huge budget; we give a lot of service. We have got a lot of problems, but I cannot accept the use of the word "crisis" in this sense. However, if you use the word "crisis," meaning that this is a turning point—Is this the point at which we are going to get better or going to get worse—then I think the word is well used because the graphs which Senator Murkowski obtained from the VA basically show one thing, that is, that we can't keep going the way we are.

We have a level budget, and we have increasing costs; and something has to change. I think that is what we are here to discuss. What is it that should change? What are the three major problems as we have them at the hospital?

My perception is that the major problem I see initially is the maintenance of quality. The second problem—and it relates to the first—is the staffing, particularly in the area of nursing and particularly in the area of critical care nursing. And the third problem—also related to the first two—is a funding problem.

I would say it isn't just dollars, though; it is the way those dollars are sent out, the way they are available to us, and the way we are permitted to use them in terms of timeliness and effectiveness of use.

I am going to prove the point that I am a doctor first and a manager second by admitting that I don't know what the total budget of my hospital is. That can, of course, be provided and will be for the record.

[Subsequently, the Veterans' Administration furnished the following information:]

Budget for Durham, North Carolina, VA Medical Center is as follows:

Fiscal year 1988 (actual)	$67,377,589
Fiscal year 1989 (target)	67,400,873

Dr. NEWCOMB. I believe that answers the specific questions that were asked, and I will stop here. Thank you for letting me do this.

Senator MURKOWSKI. I won't ask you how much is your budget. [Laughter.]

Senator MURKOWSKI. Give it to us for the record.

Dr. NEWCOMB. Thank you.

Chairman CRANSTON. I have to depart briefly to go to the Foreign Relations Committee. I would like Senator DeConcini to preside. Thank you very much for your presence.

Senator DECONCINI. Ms. Coulter, please, who is the Chief Nurse at the Boston VA Medical Center.

STATEMENT OF CAROL COULTER, CHIEF NURSE, BOSTON VA MEDICAL CENTER

Ms. COULTER. I am Carol Coulter, the Chief Nurse of the Boston VA Medical Center. I have been in the VA 14 years. Prior to my career in nursing, I was a corpsman in the Navy.

In response to your question, the problem is now. We have been dealing with it at the Boston VA since 1986. We sit in the Boston VA with 10 teaching hospitals within a 2-mile radius, whose rates are subject to change within a month or 2 months; and their rate increases are anywhere from 10 to 30 percent.

Our problem is the crisis in nursing. We have been running up to 80 RN vacancies alone. We do have 192 beds closed due to the nursing shortage in the Boston VA. We are trying to increase the number of RNs so that we can open those.

We also have a limitation on the patients who can be admitted because the number of beds that we have available are always full; so some of the scheduled admissions are delayed up to 2 to 3 weeks, particularly surgical admissions. And we have done this scheduling in conjunction with the physicians so that we can give the best care we can give with the nursing staff that we have to the patients that we bring into the hospital.

We also have increased our activities in the ambulatory surgery area. Those problems in the future will grow. The Boston area has lost three schools of nursing; the last one will probably close in early 1989.

The number of nurses available and the dollars available are very difficult. We sit with beginning rates for an RN at our medical center at the 19th step. This is the fourth raise that we have had—special rates, which we appreciate—in the last 14 months; over those 14 months, we have had four raises. The beginning salary is $26,000 and change; the salary in the city of Boston for a brand new graduate is $30,000 to $33,000.

The crisis will continue. The raises that we received this time, 30 of my RNs did not recognize any dollars because we have exceeded the dollars that are available within the grade scheduling that we have for nurses.

My recommendation is that we give consideration to the grades so that, when we look at the nursing salaries, we can be responsible to it in the Boston area. In order to keep the nursing staff going in our medical center, we have been allowed through our director to hire contract agency nurses and also to hire what we call "fee basis" nurses.

With the agency nurses, we contract with six or eight agencies in the city that supply nurses; and we call them and ask for an RN or LPN, depending upon what our needs are, either daily or weekly. The fee base is a nurse who is paid different dollars—$23, $24, and $25 an hour—depending on the tour that they work; and they work according to our needs and sometimes according to their own personal life.

So, that compliments our staff and has helped it out. What we have tried to do is be innovative. We have used medical students in the form of health care technicians. We started that about a year ago with a couple of individuals, and it was a very responsive kind of activity for our nursing staff, patients, and for the individuals.

This past summer, we were fortunate enough to have 30 of those individuals who worked on the wards in a technician status with the patients and the nursing staff, which was very helpful for us to get through the summer.

I do not believe that the worst is over as yet, and I do believe that, as far as the nursing crisis in the city of Boston or the Massachusetts area, has yet to be over. We have so many hospitals, so many areas; and the dollars are incredible. In last Sunday's paper, if you had 10 years experience, your opening salary was $50,000.

I think that I have answered the three questions. The problem is now and in the future.

Senator DECONCINI. Thank you, Ms. Coulter. You used the word "crisis" as a nursing condition in Boston. Would you characterize the situation at the veterans' center in Boston also as a crisis?

Ms. COULTER. Yes. Also, as Chief Nurse for the Medical District No. 1. There are eight hospitals in the northeast area, and we all have had our fair share of it; but the Boston VA Medical Center has had the largest because we are the inner city hospital, and we do sit with 10 teaching hospitals in a 2-mile radius.

Senator DECONCINI. How many years have you served our veterans?

Ms. COULTER. Fourteen.

Senator DECONCINI. Fourteen? Thank you very much.

Ms. COULTER. You are welcome.

Senator DECONCINI. Dr. Rogers?

STATEMENT OF DR. ELIZABETH ROGERS, CHIEF OF STAFF, BALTIMORE VA MEDICAL CENTER

Dr. ROGERS. Thank you. I am Dr. Elizabeth Rogers. I started in the VA in 1971 when I did part of my training at the Durham VA, where Dr. Newcomb is from. I continued as a staff physician originally back in the early 1970s when I joined the VA because I thought that it stood for quality health-care and was an opportunity educationally to turn on both young physicians and nurses and other health care proprietors and stimulate them to think about giving the highest care they can give.

I started the quality assurance program at the Baltimore VA and became Chief of Staff there in 1982, and I remain Chief of Staff. I also am Chairman of the Regional Planning Board for the Middle Atlantic Region.

Baltimore is a small hospital; it is a tertiary care hospital. It functions with a recurring budget projected for next year of about $37 million. The percentage of patients who are category A is in the high 90's. The hospital has never been well funded. It is a hospital that has prided itself on giving very high quality care without a lot of staff, without a lot of resources.

It clearly has been hurt worse this year than ever before. If 1989 were to be funded at the levels currently projected, it would be worse than a crisis.

Senator DECONCINI. Worse than a crisis?

Dr. ROGERS. We would not be able to deliver the care to the patients we delivered the care to this year, and this year we have turned away patients that we have never had to turn away before.

Senator DECONCINI. Excuse me. Dr. Newcomb says that if it is worse than a crisis, the patient dies. Is that what you are saying?

Dr. ROGERS. I think if we can't give care to patients who are having heart attacks, and we can't take care of patients who have cancer, and we can't take care of patients who are having other major problems, then they die.

For the health-care workers, that is sometimes worse than their own dying because it hurts inside; and that is a significant problem.

Crisis is a difficult word, and I think that is what we are all trying to deal with. The problem didn't start yesterday afternoon; the problem really is one of very slow erosion. I think that if you make the analogy of a tree that you prune, you can prune a tree and make it healthier and make it put out new sprouts in new directions; and I think that, for good and healthy reasons, the VA budget has been pruned in a conscious effort for the last 8 or 10 years.

There are points in taking care of this tree that, if you cut it back too far, you cause it stress. If the tree survives and there is plenty of rain, there is no problem. If you cause a stress and on top of that you have problems beyond your control, you can make it go to the point that that tree can't respond and can't grow.

And I think that is where we are very close to getting. For the small budget that we have, just in the last 4 years, our recurring budget has been cut a total of $1.7 million by specific programs that have been pulled out.

Senator DeConcini. How much is your full budget?

Dr. Rogers. $37 million.

Senator DeConcini. $37 million?

Dr. Rogers. In addition, just responding to Public Law 100-322 for next year, we expect another $2 million deficit. If you add to that the new programs which have occurred, the increased acuity of care, the increasing need to use contracts because VA salaries are noncompetitive, and we have found that we can bring in physicians with a contract; we can bring in nurses with a contract if we can afford to pay for them.

Senator DeConcini. Obviously, Doctor, you asked for the full funding. Is that right?

Dr. Rogers. Yes, sir.

Senator DeConcini. And what happens is that the Central Office says "No"; and then, you are left holding the bag. Is that what it amounts to?

Dr. Rogers. The system is not set up that we can ask for what we would necessarily like. The system is set so that, based on a historical budgeting and based on what is available from Congress through the distribution, what is given is what is available to give.

Senator DeConcini. So, it comes more from what the agency as a whole can petition and get from Congress or that the administration can get from Congress?

Dr. Rogers. That, plus the priorities set within the administration. Yes.

Senator DeConcini. Yes, and of course, obviously what they ask for when they ask Congress for their budget for any agency—but in this case, the VA.

Dr. Rogers. Yes, sir.

Senator DeConcini. Thank you. Did you have anything else? Go ahead.

Dr. Rogers. In terms of the specifics that were asked for, the way that we have dealt with the budget this year is that we have been in a hiring freeze since April 1 of this year. So, we have not been bringing on new personnel with very small exceptions.

We held over 70 percent of our equipment dollars and our M&R dollars. We have projected next year to not be able to use any of that money.

The downfall of that, in addition to knowing that equipment is running out, are very specific examples. We have X-ray equipment in our screening area; we have emergency patients who come in. The film processor there is irrepairable; it is 20 years old. Our medical engineering can't fix it; the parts are no longer available. We can't afford the money to fix it.

Our inventory is very low, and I would have to say that we are one of those hospitals that have not been able to put prosthetics out in a timely fashion, nor other medications.

The issue came up about whether denial of care is also delay of care; and I would say that, if you have a patient who has a lung cancer, and you delay his/her care because you can't get him/her into an operating room and the disease spreads, that is denial of care.

If you have a patient who has vascular disease, and you can't afford the vascular prosthesis for the graft and he/she gets into trouble, that really is denial of care.

So, I think that these delays are truly denials of care.

Senator DECONCINI. Now, your example of the equipment—not having the money for the equipment—does the Central Office, does the Agency, know that?

Dr. ROGERS. It is number one of one of our priority lists that have gone in, but the VA has not been able to fund those equipment lists.

Senator DECONCINI. But they know it?

Dr. ROGERS. It is on the equipment list.

Senator DECONCINI. So, in the process of developing the budget going to OMB and going through the process eventually to Congress, you are satisfied that that has been brought to the attention at least at the Agency level in making the request for funds to the Congress?

Dr. ROGERS. I can't tell what goes on beyond the local level and the regional level. It is on the priority lists at those levels and makes up the list of what is needed——

Senator DECONCINI. So, it goes to the regional level. You don't know if it goes on up to the Agency, to the Director's Office, in formulating the budget?

Dr. ROGERS. I don't know where it goes; I do know it goes into Central Office.

Senator DECONCINI. It does go into Central Office?

Dr. ROGERS. Yes.

Senator DECONCINI. So, it is here in Washington after you submitted it to the region?

Dr. ROGERS. Yes, sir.

Senator DECONCINI. Thank you. Do you have anything more?

Dr. ROGERS. No, sir.

Senator DECONCINI. Ms. Bishop, Senator Cranston is at the Foreign Relations Committee and would like to be here for your testimony. If you could just wait a minute, we will go to one other question. If he gets back, he wants to hear your testimony. So, if you could just hold up a minute?

Let me ask just one quick question here, and then I will yield to the ranking member. Would each of you tell us whether, in your experience, this is the worst condition that you have witnessed in the VA health-care system?

Ms. COULTER. Yes.

Senator DECONCINI. Ms. Bishop?

Ms. BISHOP. Yes, it is.

Dr. ROGERS. Yes, sir.

Dr. NEWCOMB. I hate to always be the person to disagree. In 1952, we turned a patient away from the Seattle VA Hospital because the VA gave no outpatient care; he had a smashed thumb. Some days later, he returned to that hospital with full-blown tetanus, and we took good care of him as an inpatient at probably 1,000 times the cost.

Except for that period in time, I think now is the worst time I have seen.

Senator DECONCINI. All right. Doctor?

Dr. MUSSER. It is the worst in my 26 years.

Senator DECONCINI. Mr. Johnson?

Mr. JOHNSON. Fiscal year 1988 has been the most difficult year I have been through.

Senator DECONCINI. Mr. Hawkins?

Mr. HAWKINS. To answer that question, I asked my medical staff, along with the nursing staff, that same question; and the answer was: It is the worst that they have seen in the last 25 years.

Senator DECONCINI. Dr. Goff?

Mr. GOFF. Yes.

Mr. FARSETTA. Yes.

Senator DECONCINI. Thank you. Mr. Ptak, I will yield to you for questions.

Mr. PTAK. Thank you, Senator. I was wondering if each of you, very briefly, could just discuss some of the congressional mandates which make it difficult for you to manage your facility? We can start with Mr. Farsetta, please.

Mr. FARSETTA. I think the mandatory employment ceiling that we have makes it difficult to manage because the dollars are not there to support that. I think the FTE level is needed, but we simply don't have the dollars to do it.

The limitations that are placed in the various categories of employees, the 200 ceilings, the 400 ceilings, the 500 ceilings, where we do not have flexibility in those accounts, I think that is a mandate that makes our job very difficult.

I think the overall funding level that we have received from the Congress essentially has not been adequate to do what we need to do; and I think that goes for medical care; and I think that goes for maintenance and repair; and I think that goes for construction; and I think that goes for minor construction.

Senator DECONCINI. Yes.

Mr. FARSETTA. And just as a general comment—and I am not in the position of the gentleman from Boise and the gentleman from Indianapolis—but in order to be an effective manager in today's environment, I think we need all the flexibility that we can possibly get. All of us are highly trained, highly educated, with training in management; and you cannot tie a manager's hands and then hold that manager accountable for managing, in my case, a $110 million budget.

The other point I would like to mention, which hasn't been mentioned at this table, is the whole issue of AIDS and AIDS funding. I think that there seems to have been at least a national recognition that AIDS is a crisis, that AIDS funding both in the private sector and in the public sector is inadequate.

I think the Veterans' Administration has identified about $109 million that they feel they need for the current fiscal year to manage the problem of AIDS, and it would appear that we are going to be allocated about $23 million to deal with that, which is roughly $80 million short of what is necessary.

I think if the mandate is there that we take care of AIDS patients and those individuals fall into category A, then the dollars have to be there to meet that demand.

Mr. GOFF. There are two areas that make it difficult to manage. The things that Mr. Farsetta has just mentioned are not a problem for us in Boise right now because of the pilot program—many of the caps and ceilings don't apply to us. But the variety of entitlements and eligibilities for veterans for care, create confusion. We have the original title 38 with service-connected at different levels, nonservice-connected, retirees, et cetera. That was never rescinded.

On top of that, we came up with means test eligibility—categories A, B, and C—and Agent Orange, POWs, ionizing radiation, PTSD, and all that kind of stuff. And then, on top of that, we now have Public Law 100-322, which has categories 1, 2, 3, and 4 eligibilities and entitlements. If you try to put all that together, it is mind-boggling.

It is mind-boggling to us; it is to the veteran; and it is often difficult to sort it out in trying to establish priorities for who you are really going to give the care to.

The other area that is of concern to me is beneficiary travel. The way the entitlements are written, there are, in my opinion, people who get travel who probably don't need it and others, to whom we ought to be giving travel, who don't get it. I will give a couple of examples.

When we see a veteran in Boise as an outpatient who needs care in Portland, 450 miles away, I think we ought to pay his travel to get there; but if he is an outpatient, we don't pay it. Portland has to pay it at some reduced rate, but a lot of these people can't drive; so they have to fly. The amount of money they get nowhere near compensates for the cost of getting there.

On the other hand, we pay for people to come in for exams and so on who really don't need to get that travel money. So, I would like to see us not pay for people to make that initial entry to the system, but to pay once they are in the system. If we have to send them to another facility for care, then we should pay for that, whether they are an inpatient or outpatient, but not pay for them to initially access the system.

So, those are a couple of comments that I had.

Mr. HAWKINS. In my opinion, one of the biggest problems is the inflexibility of being able to manage your resources to get the most bang for the buck; and I am referring specifically to both ceiling and money. For example, we have a personnel ceiling with an overall ceiling count that we have to meet; within it overall ceiling we have a 200 series, which is the medical and ancillary personnel; that is fenced in terms of the ceiling.

We have the 400 series, which is the administrative ceiling, and then the 500 ceiling, which is the maintenance ceiling. And we have to meet those ceilings on a monthly, a quarterly, and an annual basis. At times, you need to be able to move your money and your ceiling to meet the existing needs.

For example, it takes time—maybe up to 6 months—to recruit certain physicians. Those moneys could be used to hire more file clerks; and I think my medical staff tells me that they are in dire need of medical clerks to take up doctors' orders, to clean up medical records, and things like that. But I don't have the flexibility of moving those resources to do that.

The other thing that relates to that is the funding of various nonrecurring programs, such as utilities, nursing home care, contract hospitalization. All those moneys are earmarked moneys that leave no incentive to try to utilize those more efficiently in order to use those resources against bona fide needs at the hospital.

Mr. PTAK. Thank you.

Mr. JOHNSON. I think a number of the positive comments have already been made. Let me just add mine to that. The management efficiency pilot program is a very helpful program in allowing us to be more flexible at the local level.

It allows us to be exempt from the various ceilings and head counts and that sort of thing. It has had the most benefit for us in fiscal year 1988, during this very tight budget situation by allowing us to reprogram non-VA workload accounts to the tune of around $300,000-plus into direct patient care. And this has allowed us to continue to meet our obligations to our inpatients and outpatients.

I would also comment on another area that would be very helpful to the field if some action could be taken. Frequently, additional programs come to us that are either unfunded or underfunded and we are required to absorb those costs at the local level. A good example of this, from a couple of years ago, would be the third-party reimbursement program.

We are putting forth a significant effort to meet our collection goals in Indianapolis. It is taking a lot of FTEE to meet our responsibilities for which we were never funded. There are a number of other new programs and benefits identified in Public Law 100-322 that apparently have not been funded; but they do have staffing and cost impact at the local level.

The administration of the new beneficiary travel criteria, for example, in Indianapolis takes additional FTEE just to fill out all the forms and make sure everything is done right. An additional one and a half FTEE are required; and that certainly hasn't been funded.

Dr. MUSSER. I would agree with the comments presented in response to your question, and I would only emphasize what I tried to emphasize Wednesday in testifying before the House, that this is not something that just began this year, that it is a cumulative problem, that we have always been thankful to the Congress for the legislative entitlement gave us the authority to do our work, but that the necessary moneys to follow up that entitlement was a bit lacking.

The classic example is Public Law 100-322, and I won't go into that. I was going to mention AIDS, but let's mention another little part of that whole problem. The universal precautions that we are now required to introduce which address infectious diseases—AIDS being part of it—we now find that it will be difficult to implement these precautions.

They were not funded, and the impact on our institution alone will be $638,000—over a half a million dollars. That is going to have to come from somewhere. Now, we intend to do it because it is good medicine; it is safe; it is necessary if you are going to call yourself part of modern medicine; but somebody has got to pay for it. We will find it somehow, but it will be the same old story over and over again.

We will reduce care in other areas in order to keep the quality of the care in what we do do at the highest possible level.

Mr. PTAK. Thank you.

Dr. **Newcomb**. Two concerns that I would have about mandates from Congress are, first, relating to entitlement and eligibility. I think we have more problems that derive from the expectation services which are to be provided on a funding and resource availability than to do with anything else.

The problem with that is that the final decisionmaking is forced onto the care provider, usually the physician, and sometimes the nurse or the technician involved with the case. And it encourages them to take shortcuts which possibly might interfere with quality.

The second area of major concern has to do with the area of provision for rapid changes in the marketplace. I think the nursing shortage is a good example of this. We have to lose our good nurses, show that we can't hire new ones, before the problem can be addressed. Now, if we could stay anywhere close to the competition, if we could stay within 10 percent below the median of the community, we could keep the nurses we have. They like to work in the VA, if we could just keep their work rates reasonable.

They just can't afford to be very far behind their counterparts in the private sector. I think in order to accomplish that, we need somehow to index a salary of scarce professionals so they can keep up with rapidly changing times. That is not presently a mandate, and I think it is one that could easily be provided. We do it for blue collar workers; why not do it for these other people?

Mr. **Ptak**. Thank you.

Dr. **Rogers**. I don't think that the issue is ceilings, although you have heard that. I think the issue is really funding, and I would venture to say that, at least at my medical center, we need every one of the FTEE that we have on our ceiling. Being able to pay for them is a major problem.

The issue of how you hire people, though, I would say is one of the congressional areas that probably causes the greatest havoc and will cause the most havoc as health-care workers become less plentiful. And I think we are focusing in on nurses and for very good reasons, but the same is true for physical therapists and respiratory therapists and technicians and X-ray technicians and nuclear medicine technicians and physicians.

The ability for us to hire quality people with the regulations on salary, the regulations on hiring, the inability to promote, the inflexibility on hours, puts us in binds that means that we can't get people when they are available and when they want to work at the VA.

Mr. **Ptak**. I see that the chairman has returned; and since he has not had an opportunity to hear from Ms. Bishop, I will turn it over to you, sir.

Chairman **Cranston**. Yes. I want to especially welcome you to the committe; and I would like to remind you that I am most of all interested in your stating your current position, your experience and the length of your experience in the system, and your characterization of the present situation, whether you believe it is a crisis in your own area and, from what you know, is it that nationwide? And please give a few examples of what you consider the worst situations.

Would you try to be brief? Senator DeConcini wants to come back, but he has something he needs to do at 11:30. Please proceed now.

STATEMENT OF ROWENA BISHOP, CHIEF NURSE, WEST LOS ANGELES VA MEDICAL CENTER

Ms. **Bishop**. Yes. First of all, I have been in the VA approximately 18 years and as a chief nurse since 1974. I have served at five VA hospitals: San Francisco, Palo Alto, Reno, Albany, and now at West Los Angeles, where I have been since 1979.

Of course, I feel very much so that the nursing situation is a crisis in southern California, and it is becoming a crisis throughout the United States. I feel very strongly that the primary reason why patients are admitted to medical centers is because they need nursing care; and without nurses, hospitals close.

I think this has happened in the private sector, and I would hate to see it happen with the VA medical centers that do provide quality care, I think, at a much less cost than the community hospital can provide.

I currently have 85 RN vacancies; I did have as many as 90. We have had to close beds—critical care beds—because of an absence of RN staff. The primary reason for RNs leaving us is because of salary. The second reason they give us is workload. I have no doubt that the nursing personnel within the VA system work much harder than they do in private hospitals.

Even at West LA, their staffing is less than the county hospital; and it would seem to me that we would be able to provide care at least equating what the county provides their patient population. At the closest county hospital for a similar size ward, they are staffed at 4.9 to 5.4 hours per patient day. My most heavily staffed ward is only able to provide 3.7 hours per patient day; and I think that needs to be looked at and corrected.

Going back to the salary situation, I think what we need is to become, as Dr. Newcomb mentioned, proactive rather than reactive. The last time our salaries fell below the community level, it took us 5 months before we were able to become comparable to the community. And within that 5 months, we lost nurses.

We in region VI do have a task force that has convened to look at a possibility of indexing with a community hospital or an affiliated hospital so that we can become proactive with the salary situation. Another thing that could be done is perhaps waive the statutory salary scale as they did for nurse anesthetists.

And of course, a third one, which Carol Coulter has mentioned, is to look at the grade structure, which I understand would also require some legislative action.

Chairman **Cranston**. Does that finish your statement?

Ms. **Bishop**. Yes, for now.

Chairman **Cranston**. Thank you very much. I didn't mean to rush you.

I would now like to change the order of business just briefly since Senator DeConcini has a commitment he can't avoid fulfilling elsewhere at 11:30. Dr. Musser, would you please make room for Mr. Turnage to come forward?

Mr. Turnage, would you just come up to the table briefly for Senator DeConcini? I apologize for removing Dr. Musser briefly; we expect to have you back.

Mr. Turnage, you will be given an opportunity later to make your own statement and to answer other questions; but Senator DeConcini has a few questions he would like to put to you at this time.

Senator DECONCINI. Mr. Chairman, thank you; and Mr. Turnage, thank you. I am sorry, General, but I just cannot get out of another appointment, and I do have a couple of questions I want to ask you. First, I want to tell the panel here that I am very impressed with your forthrightness, and I realize the perhaps difficulty or at least awkwardness of having to come and discuss with us these hard facts and problems that exist here.

No one questions anybody's loyalty, including you, General Turnage—you have a distinguished career—as to the loyalty to our Government and to the Agency that you serve and you have served for so many years; and you have my compliments for that.

So, please take this Senator's gratefulness for the demonstration of giving us the facts that we need to know about the crisis that exists here.

General Turnage, the reason I wanted to have a chance to pose questions to you is that my concern is that something is amiss here; and I don't know where it is, and you may be here in the next administration and you may not. Those are questions that are going to be answered by a lot of Americans on perhaps entirely different reasons.

What I am concerned about is: How do we get in the position we are in today? How do we have all of these administrators, with the exception of one, saying that this is a crisis? And that certainly was a crisis in a different frame. That it is the worst situation except for 1952, by one doctor; that it has been coming on us for a long period of time; that the Central Office is aware of the needs and yet they are not provided for?

Maybe it lays right here with us. Maybe it is us. I would appreciate your analysis of why we are in the position we are in because it is very clear from this testimony that we have a crisis on our hands, and Congress and perhaps you and OMB and others have not provided the necessary resources to keep us out of this crisis. Can you comment, General?

Mr. TURNAGE. Yes, I will; and it won't be to the extent that I would like, but I will give you some aspects of it, which I think are important, sir.

First of all, let me suggest that, by making the following statement, I am not trying to absolve myself of any responsibility as the Administrator for this Agency and the position in which it finds itself; but I do note that almost universally here, both in the previous testimony by the representatives of the veterans' service organizations and the representatives here, they talked about the fact that this situation has been coming on over a long period of time.

There are a number of factors that relate to it, and I think that you pointed out very clearly that part of it rests with the responsibility of the Congress. The Congress has been very generous, more generous than any other nation in the world, with its veterans; and I don't criticize that.

I am the Nation's principal advocate for veterans, and I feel that very strongly. That is my responsibility, and I take it. But on the other hand, when you have a difference of timing and backlog between the benefits that are provided and entitlements that are provided and then the funding process that follows up, you find out that you have a very serious deficiency; and that was aggravated this year simply because of Public Law 100-322. That is a case in point.

Let me give you another couple of specifics. We had to make certain projections for the fiscal year 1989 budget before we knew about those entitlements and some others that have come along as a result of policies or procedures or situations developed because of the agreement made between the administration and the Congress, as opposed to sequestration.

And then, when that went forward, we had already gotten our appropriation; and as a result of that, we now have what is considered to be a projected backlog for 1989, and the process is such that we don't know that there is a procedure now in order to get those funds so that we will have them available to these directors starting October 1, as opposed to some kind of delay before we will know what we get and when we will get it.

Senator DECONCINI. General Turnage, did you submit that necessary shortfall that was created through the summit agreement in the 1989 request?

Mr. TURNAGE. We did not know precisely at that time what it would be. For example, we had no idea about Public Law 100-322. That law, for example, was passed in May of this year; and as a result of where we stand now, we have already based on the projected shortfall that we know to exist, we have submitted a supplement to the OMB for fiscal year 1989.

Senator DECONCINI. But that reference was about $100 million. We are talking about over $600 million in shortages here; that only accounts for one-sixth of it.

Mr. TURNAGE. Sir, I am privileged to tell you that we have submitted a supplement to OMB based on what we consider to be the shortfall for 1989. I am not privileged to tell you any other aspects of it because it is embargoed information.

Senator DECONCINI. It is embargoed by whom?

Mr. TURNAGE. It is embargoed by the administration. We are not obligated to give that information before the President submits his budget in January of this next year.

Senator DECONCINI. General Turnage, you know, it troubles me. You have a tremendous background and record as a veteran and as an active soldier, and you say you are the advocate of the veterans. But I remember at your hearings that you told me and other Senators that you were prepared to go and talk to the President, if necessary, even though you are not a member of the Cabinet, if you did not get the funds that were necessary.

How many times have you personally visited with the President regarding your budget for the Veterans' Administration?

Mr. TURNAGE. I have talked with the President on a number of occasions since I became the Administrator. I have not talked about details of the budget with the President.

Senator DECONCINI. You have never asked the President or petitioned the President that your Agency should have more funds than what the OMB has allocated for your Agency?

Mr. TURNAGE. My issue with the budget situation has been with OMB and, on one or two occasions, with the Chief of Staff in the White House.

Senator DECONCINI. And never to the President?

Mr. TURNAGE. I did not find that necessary, sir.

Senator DECONCINI. How could you say you didn't find it necessary? You are short a lot of money; why didn't you go to the President?

Mr. TURNAGE. I think, Senator DeConcini, that I expressed why some of the shortages exist. Now, let me put it in another perspective, if I may. With this current fiscal year, we have $422 million more than we had last fiscal year.

Part of the problem is not across the board in the system; part of the problem is the allocation of resources among the 172 medical centers, as well as the 232 outpatient clinics, as well as the nursing homes, as well as the contract nursing homes, in order to come up with the most equitable allocation of those funds so that where the requirements exist, the dollars go.

And we have many things that have happened in the meantime.

Senator DECONCINI. But, General Turnage, you are begging the point. You have eight or nine people here who tell you they are in a crisis, that they can't buy equipment, that they can't fund things, that they can't deliver the services. Do you know that?

Mr. TURNAGE. We have 172 of them, sir, and I have visited 64; and I know some aspects of this——

Senator DECONCINI. I was not asking how many you visited. I am saying: Did you know that these crises existed? Maybe you didn't.

Mr. TURNAGE. I did.

Senator DECONCINI. You didn't?

Mr. TURNAGE. I do. I am aware of their situation.

Senator DECONCINI. All right. And you were aware of them before today?

Mr. TURNAGE. Yes, sir, I have been.

Senator DECONCINI. All right. Now, based on that and other crises that may have occurred, what kept you from going to the President—to the Chief Executive—in behalf of your Agency?

Mr. TURNAGE. When Public Law 100-322 was passed reflecting the kinds of problems that are existing in the system now, we did go for a supplemental; but let me go back earlier, if I may.

You asked why not. Last December, I did not make the agreement between the administration and the Congress about the summit agreement for funding in this Nation. Sir, the Congress did; and you probably voted for it.

Senator DECONCINI. That is a fair statement.

Mr. TURNAGE. And when you did, you said that agencies would not go in for supplementals.

Senator DECONCINI. All right. Let's talk about 1977 and 1976. You were there in 1977 and 1978; did you go to the President in those years?

Mr. TURNAGE. We had adequate funding, and no veteran who had eligibility entitlement was turned away for care.

Senator DECONCINI. Now, wait a minute. We just heard here clearly that this has been going on for 8 or 10 years. We didn't just dump on it as of the budget summit for 1988. This has been going on for a long time; you said that yourself.

All of these people said it has been going on for 8 to 10 years, and we have just been cannibalizing and not fully funding anything. My problem, General, quite frankly, is that you, as the Administrator, left a distinct impression with this Senator—maybe not the whole committee—that you were prepared to go to the President to get the funds.

Now, if you couldn't get them, you couldn't get them. You can't squeeze something out that isn't there, but I don't think you fulfilled that commitment. I don't think you went to the President like you told this Senator you would.

Mr. TURNAGE. I suggested a moment ago in my response to you that I didn't go because I didn't think it was necessary then, and I didn't think it was necessary now.

Senator DECONCINI. You don't think it is necessary now?

Mr. TURNAGE. However, I feel that, within the context of the whole, we have received adequate support until now. I think now we have a problem, and I have said so.

Senator DECONCINI. Are you prepared to go to the President now and argue in behalf of your Agency?

Mr. TURNAGE. I have not had to go, sir. I think we have got adequate things going on now to correct the problem that has been expressed here this morning.

Senator DECONCINI. Mr. Chairman, I think the case here rests that that is not the situation, that we do not have adequate funding, last year, this year and in the 1989 request.

Mr. TURNAGE. Forgive the interruption, Senator. We don't have adequate funding now, and I think I suggested that. I said we have a problem. I said that we have sent the supplement already to the administration requesting additional funding.

Senator DECONCINI. And you are not prepared to go any further than just submitting the supplemental and just taking whatever OMB does?

Mr. TURNAGE. If we get the supplemental, then we will meet our requirements. If we don't get the supplemental, it may be a point where I would find it necessary to go to the President. That option has not been necessary up to now.

Senator DECONCINI. You have said in the past—I think just last week, or maybe earlier this week—that anyone who tells you we are not well-funded, I think they "are whistling Dixie," was your quote. You know, you are not well-funded, General. Maybe you don't understand that.

And if you think people are whistling Dixie here, I think it is more the Battle Cry of the Republic. You know, maybe that was an off-the-cuff remark you made; I certainly make them and don't always mean them.

Mr. TURNAGE. Sir, it wasn't off the cuff, but it was in the context of what I considered to be malicious kinds of criticism of the Agency and the fact that the Agency was going to hell in a handbasket; and I wanted to point out in some emphatic way that I took exactly an opposite view.

There are so many aspects of it now that should be emphasized that, if you want to take the time, I will be glad to do so. For example, we talk here about the maintenance situation. Last year, in fiscal year 1987, the Agency spent $770 million for renovation, refurbishing, or new construction. That is more money in real dollars than has been spent by this Agency since 1945.

Right now, Senator, there are $1.6 billion in the process of being spent for construction and refurbishing and renovation in the system, which hasn't been recognized in the discussion here. I did not hear about the situation at Brooklyn; there is a $660,000 contract going on right there now to upgrade the food service situation in that hospital. I wish that something had been said about that.

Senator DECONCINI. General Turnage, let me ask you this. In August, you submitted a supplemental to OMB, and they refused to approve it. Is that correct?

Mr. TURNAGE. Yes, sir. That is correct.

Senator DECONCINI. Yes. Now, did you decide to go to the White House on that?

Mr. TURNAGE. No, sir.

Senator DECONCINI. Why not?

Mr. TURNAGE. There was a reason for that, Senator. If you knew that this action occurred, then I think it is also important that you must have known how it occurred. For example, we had the commitment out of OMB until the morning of the submission that it had been approved. In anticipation of that, we took that information to this body, and we took the information to the House Veterans' Affairs Committee and the Appropriations Committee and said this is what we need as a result of that action.

Senator DECONCINI. Why didn't you go to the President?

Mr. TURNAGE. OMB in the meantime, in the same day, said we will not go forward with it; but in the meantime, this committee had taken the action in order to get that supplemental. And it was acted upon; and we needed it, and we got it.

Senator DECONCINI. OMB said no; the committee said yes.

Mr. TURNAGE. I agreed to that, sir.

Senator DECONCINI. And you did not decide that you had to go to the President to overrule OMB.

Mr. TURNAGE. We got the money, sir.

Senator DECONCINI. But doesn't OMB sometimes make mistakes?

Mr. TURNAGE. Indeed.

Senator DECONCINI. And isn't it your duty to carry that and to carry that appeal beyond OMB?

Mr. TURNAGE. And when I find it necessary, I do so.

Senator DECONCINI. And you talked about a supplemental for January 1989, that you know you are going to have a shortfall. Why isn't that supplemental going to be in before that?

Mr. TURNAGE. It is in already, sir. We put it in on September 1.

Senator DECONCINI. All right; and are you ready to go to the President if OMB turns it down?

Mr. **Turnage**. Indeed I am because I figure it is very, very important at this stage of the game.

Senator **DeConcini**. That is encouraging, and I hope that you do that. I am going to watch with great care because, it seems to me, General, that I am willing to take plenty of blame up here, too. I don't lay it just on you; but it seems to me that, for someone who is going to be the advocate of the veterans——

Mr. **Turnage**. No, sir. I am not going to be; I am and I have been.

Senator **DeConcini**. Well, I don't think you have been.

Mr. **Turnage**. That is a matter of opinion.

Senator **DeConcini**. I don't think you have been an advocate to the fullest extent that you told this committee because you left this committee, or left this Senator, with the distinct impression that you were ready to go to the mat; and that is why I was so encouraged when you took over. I said here is someone who has been through this, who has been in the service, who understands that sometimes you have to take your cause all the way to the President.

You said you had done that before, or rather to the Joint Chiefs of Staff when you were in the service.

Mr. **Turnage**. Yes.

Senator **DeConcini**. And you were prepared to do it here.

Mr. **Turnage**. I am.

Senator **DeConcini**. And now you are telling me: I am going to do it on the 1989 supplemental. That is better than nothing.

Mr. **Turnage**. I am telling you, sir, that if I don't get the results out of OMB that we think are appropriate. That is what I told you.

Senator **DeConcini**. You haven't been getting them from OMB. Right?

Mr. **Turnage**. That is your view, sir.

Senator **DeConcini**. All right. Mr. Chairman, thank you for letting me ask these questions because I think it is so clear that we have to work closely not only with the Administrator and the regional people, but it is just imperative that someone has the courage and the gumption to go all the way to the President of the United States when you are dealing with the veterans of this country and when commitments are made.

I am very disappointed that General Turnage justifies not doing that. That is his prerogative. He is the Administrator; I am not. But indeed, I don't think we would be in this problem if we had somebody who pled that case all the way. Maybe we would; maybe the President would say sorry, we can't do it. If he says that, fine. I understand what a soldier is supposed to do, and as part of the administration, you have to pick up and defend it.

I am not sure President Reagan has any idea that these budgets have been scaled down like they are and they have this crisis laid out before us today. I rather doubt that he has any idea that the Veterans' Administration is in the terrible financial shape it is in. Thank you, Mr. Chairman.

Chairman **Cranston**. Thank you very much, Dennis. Thank you very much, Tom. We will get back to you after a little bit.

Mr. **Turnage**. Yes, sir. I figured you might. [Laughter.]

Chairman **Cranston**. Thank you. Will Dr. Musser now return to the table? We asked each of you in this panel at the table to bring with you written responses to the committee request for data. Did each of you bring those responses?

[Chorus of affirmative replies.]

Chairman **Cranston**. I would appreciate it if you would make those papers available now to our staff who will pick them up from you. It is my understanding that you are providing that information pursuant to the committee's request and that you understand that you are under oath in doing so. Please signify otherwise if you do not so understand. If not, that will be the understanding. I will now start questioning, and then I will yield to Frank Murkowski.

Would you please be very, very brief in responding? You have each had ample opportunity to respond in general; so, if you would be brief in responding to the following questions.

For your facility, if you maintained through fiscal year 1989 the current level of services you are now providing and comply with the law, do you expect to be in a deficit situation at the end of fiscal year 1989? And if so, what would the size of that shortfall be? And please identify your facility.

Will you be in a deficit? How big? And what is the name of your facility?

Ms. **Coulter**. Yes, we will be in a deficit. With the crisis we have been in, we have dropped a number of patients; and we have been able to treat our inpatients from 12,000 to 8,000.

Chairman **Cranston**. What will be the figure? How short will you be?

Ms. **Coulter**. I don't believe I can give you a good estimate at this time, Senator.

Chairman **Cranston**. All right. Would you give it to the committee, within one week, please?

Ms. **Bishop**. I can't give a specific answer either, Senator Cranston.

[Subsequently, the Veterans' Administration furnished the following information:]

West Los Angeles VAMC will have a budget shortfall of $8,463,000 for fiscal year 1989.

Dr. **Rogers**. Baltimore will be short about $3.5 million.

Dr. **Newcomb**. Durham will be short $2.9 million.

Dr. **Musser**. Atlanta, $5 million.

Mr. **Johnson**. Indianapolis, $5 million.

Mr. **Hawkins**. Dallas, $5 million.

Mr. **Goff**. Boise, $2.5 million.

Mr. **Farsetta**. Brooklyn will not give an exact answer; somewhere between $6 and $10 million, depending upon what happens with the pay raise and with AIDS funding.

Chairman **Cranston**. Thank you all very much. We are now going to go to Frank Murkowski.

Senator **Murkowski**. Thank you, Mr. Chairman. I have listened to the witnesses with great concern as we address the issue of the crisis; and I think it is fair to say, Mr. Chairman, that we do have a shortfall. There is no question about it.

The question is: What are we going to do about it? Is the recommendation of the panel and the witnesses that we simply provide more money? Is that the answer? Or are we going to have to initiate innovation—innovation to do things that we haven't done within the VA?

I listened particularly to the gentleman from Boise, who was sharing the realities associated with rural care, where it is costly to send a veteran to a hospital for a transplant when the Boise hospital doesn't provide that capability. Is it time that the VA contracted with the private sector to provide some limited services?

I know that the service organizations will come out of their chairs at the suggestion, but reality dictates that we look to new procedures, new methods—not the same old tried efforts—when we address the shortfalls that you people quite rightly are indicating as you look at your responsibility, which is to provide overall care, overall expertise, a duplication in many instances.

Are we going to have to look to a combination of a continuation of the quality care in the VA with some innovation on some specific contracting with the private sector?

The record is going to remain open on this hearing for a period of at least 10 days to 2 weeks, as is usual; is that not correct?

Chairman **Cranston**. I hope 1 week.

Senator **Murkowski**. All right, 1 week. And I know that, in the makeup of this hearing, you probably were not solicited for ideas. But recognizing a reality that the medical-care budget has increased, in spite of the doom and gloom suggested that it hasn't because, in reality, while it is increased, it has been inadequate. Let's recognize that as a given.

It was $6 billion in 1981, $7 billion in 1982, $7.7 billion in 1983, $8.2 billion in 1984, $8.9 billion in 1985, $9.1 billion in 1986, $9.7 billion in 1987, $10.1 billion in 1988, and proposed $10.5 billion in 1989. So, it has increased, but your costs have increased further.

You know, we sit here with the reality that we can provide more money; but by the same token, we are going to have to get it from some place. And that creates the problems that you live with, where you say I have a shortfall; I have to provide these same services.

I would ask anyone of you, in the interest of time, if you consider the crisis one which is associated with the inadequacy of you to do your overall job with the limited funds you have, or whether you see the crisis today as your inability to provide quality care or your inability to provide for those veterans in category A.

I happen to come from a State where we don't have a veterans' hospital. We contract for care in the private sector because of the geographical realities—somewhat different from the State of Idaho. It is an expensive system; it works. It doesn't work as well as it could; it could be improved on. Perhaps some day we will have a VA hospital.

As one person pointed out, as a comment to my opening statement, different hospitals have different obligations, work different ways, and there are different combinations of systems within the VA. You people are the professionals on the front line; and if anybody is going to create innovation, it is going to come from you.

I know that this is a departure from the norm because the VA doesn't function in the sense of providing consideration for contract care in the private sector to any great extent, but should it? Should we look toward that? Or should we simply look toward another alternative of giving you more money? And I can't tell you where we are going to get it, but there is a compromise that occurs every year as this budget for medical care has increased every year.

Anybody who would care to comment on my harangue, I would appreciate. Mr. Goff?

Mr. GOFF. Senator, I would like to make a couple of short comments. On the alternatives, we already can do that. If a veteran needs care and it is less expensive for us to provide it in Boise on a fee basis or contract than it is to send them to Seattle, Portland, California, or somewhere, then we do that.

In most cases, it is cheaper to pay for them to go to another VA, at least out of our budget. Now, maybe the other VAMC's budget is impacted; but, unfortunately, you know, we are concerned about ours. So, that is something we do, and we do look at that.

We used to do more fee or contract care and actually have cut back on it because it is more costly, and we now insist that they go to that other VA. Even though it may be inhumane for somebody who is terminally ill and needs radiation therapy to go all the way to Los Angeles for it, we do that.

Senator MURKOWSKI. According to the information I have, Mr. Goff, about 85 percent of your hospital treatment—in-house treatment—is category A veterans, those who are required to be provided hospital care; and about 10.25 percent are category C, and that is care to the extent that resources and facilities are available.

Mr. GOFF. That is correct, Senator; that is close.

Senator MURKOWSKI. And about 4 percent category B, which is limited, too, to the resources and facilities available. Do you look at that as a viable alternative—reducing care?

Mr. GOFF. Yes, sir. As a matter of fact, we are one of those who have been singled out as having begun the process of reducing the category C workload and received some flak over it, frankly, both within and outside the Agency. As I pointed out earlier, in the kind of economy we have in Idaho with a large agricultural economy and no other alternatives for indigent care, a lot of category C's are category C's because they own a farm; but they don't have health insurance, and they don't necessarily have the income to pay for their health care.

So, you have to look at who they are and what their alternatives are.

I would like to comment on your straight-line budget. You know, we provide care differently today than we did in 1977, and you have pointed out that the budget is the same now basically as it was in 1977. But no one has mentioned that the outpatient workload in the VA has doubled in that length of time. In our hospital the inpatient workload and patients treated have remained fairly constant; they have gone up slightly.

And the technology that we use today is a factor. I don't think any of us today would want to be treated in any health-care setting the same way that treatment was given in 1977. You would not want to be without a C-T scan or an MRI or many of the chemotherapy agents and other things that now exist and create the additional costs.

I think we should look at the VA budget and the medical Consumer Price Index, which is different from the regular Consumer Price Index, and see if the increases have really kept pace with that; I think you would find they have not.

Senator MURKOWSKI. One other specific question for Dr. Rogers. I believe that, since I have been on the committee, we have authorized a new hospital in your city, which may be coming on line in 1991?

Dr. ROGERS. Yes, sir.

Senator MURKOWSKI. And I assume that that has something to do with the reluctance to provide replacement on aging equipment because of the reality, if you are going to get a new hospital, I would assume that that would include new equipment. Is that a fair evaluation?

Dr. ROGERS. I think, whenever there is a new hospital, there is a reluctance to put equipment into the old hospital. I would say that a significant proportion of the impact I am talking about is the fact that we haven't been able to use our existing equipment funds for equipment, and not because of a reluctance on the part of the administration to solve crises.

Senator MURKOWSKI. Yes. Does anyone have any other comments they would care to make on any of the questions regarding whether this so-called "crisis" has resulted in your putting out less than you consider quality care currently? I recognize your forecast, and I am sensitive to it.

Dr. MUSSER. We have a fear of erosion.

Senator MURKOWSKI. Which is understandable

Dr. MUSSER. And we watch it continuously and vigilantly. You might like to know, Senator, that we have been in comprehensive health planning—medical district initiated program planning called MEDIPP for a number of years. Under the guidance of Dr. Custis, efforts to explore innovative ways to deliver health care that would be less expensive have been completed under the MEDIPP guideline.

For instance, I happen to have the privilege of not only chairing our district planning board but our regional planning board in region III; and our emphasis there has been to concentrate on nonbed care—nonbed care not just because it is cheaper, but because it is probably better medicine to treat some of these patients in this mode.

Let me tell you what I will do as a physician and what my physicians will do. We will live within the dollars. If I contracted it out, I would double the deficit that I have been discussing with you, by the way. So, that is not the solution.

But we will live within the dollars; we will arrange the care packages accordingly. And in areas like I live in, we will ration care, and we will not be antideficient. That is the bottom line.

Senator MURKOWSKI. We very much appreciate that spirit of commitment and dedication. I think it is revealing of the commitment within the VA to perform quality medical service.

Mr. Chairman, I would conclude by indicating—and I heard Senator DeConcini questioning Administrator Turnage—that the shortcomings of the VA from the standpoint of budgetary matters could also include the realities associated with the aging of America's veterans. I think we would admit that we are totally inadequate in that area—totally.

We are failing to meet that obligation—totally—yet we are not talking about that today because we are on another matter. But as we consider the needs of those older veterans and the lack of a system to care for those veterans—whether it is adequate that we contract in their communities, or whether we attempt to provide a whole new system—these are realities that the Congress is not even addressing at this time because we simply don't know where to start.

The problem is so great and the obligation so real, and I just share that to bring the issue into a greater perspective, if you will. It is not only what we provide from the standpoint of quality health-care commitments, but the reality that the changing and aging of America's veterans simply demands a different type of care than the quality commitments of some of our hospital capabilities.

I think that is another topic for another time. Thank you, Mr. Chairman.

Chairman CRANSTON. Thank you. I regret to have to say that we are not going to be able to cover the whole agenda today. Therefore, the panel consisting of organizational representatives will have to come at another time. I will try to schedule a hearing next week or the following week, and I apologize to those of you who have sat here and to those of you who have come from elsewhere to be with us.

We have had only one and a half panels disposed of thus far, and we have a very full agenda; and unfortunately, we cannot go on all afternoon. So, with apologies to those in those organization panels, we will be in touch with you about rescheduling.

I will try to be as swift as I can now; and please, you try to be likewise so that we can move on to others.

Would you now tell us of the impact on the patient or the physician or on other health-care professionals caring for that patient when necessary supplies are short or equipment is unavailable? I would like to start with our two nursing chiefs; Ms. Bishop could you comment on that point?

Ms. BISHOP. Could you repeat that for me, please?

Chairman CRANSTON. What is the impact on the patient or the physician or other health-care professionals caring for a patient when necessary supplies are short or simply unavailable? What happens?

Ms. BISHOP. The patient doesn't get the care that he requires. It may be necessary—and I hate to say this—but we have had to borrow at times supplies from our neighboring UCLA, which is somewhat embarrassing. We have also borrowed supplies from Sepulveda at times.

Yes, I think it is unfortunate if you don't have the supplies readily at hand. If it is nonemergent, then sometimes it can wait; but that is not always the case.

Chairman CRANSTON. Dr. Rogers, could you answer the same question?

Dr. **Rogers**. Yes, sir. When you are dealing with, for example, a surgeon who knows that he ought to be doing something for a patient and he can't and he waits for the known complications to start to occur, that is devastating. It is devastating for that physician; it is devastating for the other health-care team that is working with that patient and knows that that is going to happen and knows that that is not accepted medical care.

It is a problem with the family, who has to deal with that, who may know better or who does not have alternatives. It is bad for the health-care workers we are training who are coming through and watching and saying that is not the quality of care that we see in other areas.

It has a demoralizing effect that goes through the system. I would say that, when resources are tight, it is not only the direct health-care providers that are affected. But I would say that if you look at people within our medical administrative services and our supply services, they are feeling exactly the same kind of impact; and their ability to respond the way they know they should is being pulled apart.

Chairman **Cranston**. Veterans are experiencing long delays—and if so, how long?—in getting appointments to be seen at the outpatient clinics in Baltimore.

Dr. **Rogers**. Yes, sir, especially in our specialty clinics where we have approximately 10 to 15 patients a day who come into screening who need and have eligibility for those clinics; and waits can be anywhere up to 3 months, if that is the first patient through the door. We went through a computer search and looked at patients 1 to 10 available admissions and into clinics.

If you are trying to go to neurosurgery and you are the tenth patient in, you may not get in until December. If you are trying to get into a neurology clinic nonemergently, you may not get in until October 10, 1989. In primary care, if it is nonemergent, it is December 19. So, the waits are significant.

Chairman **Cranston**. What is basically the cause of those delays?

Dr. **Rogers**. We don't have enough staff to take care of the patients who need to come in.

Chairman **Cranston**. Do any others of you have any brief comment on delays in facilities and outpatient facilities?

Dr. **Musser**. We all have delays.

Chairman **Cranston**. You all have delays? How long normally?

Dr. **Musser**. Three months for some clinics.

Chairman **Cranston**. Are category A veterans being turned away?

Mr. **Johnson**. No.

Mr. **Goff**. They are being asked to wait up to 4 months for appointments; and in some cases, the nonservice-connected are being turned away because the clinics are limited to service-connected only.

Chairman **Cranston**. Would you each comment, just yes or no, on whether category A are being denied or delayed?

Mr. **Farsetta**. Delayed, yes; denied, no.

Chairman **Cranston**. How long delayed?

Mr. **Farsetta**. Anywhere from 1 week to 3 months.

Chairman **Cranston**. Mr. Hawkins?

Mr. **Hawkins**. Delayed 2 weeks to 3 months.

Chairman **Cranston**. Mr. Johnson?

Mr. **Johnson**. We are not denying category A. There are clinic backlogs ranging up to 6 months.

Chairman **Cranston**. Up to 6 months?

Mr. **Johnson**. For regular appointments; emergencies are seen as necessary.

Chairman **Cranston**. Dr. Newcomb?

Dr. **Newcomb**. Delay up to 6 months in urology; no denials unless the patient goes into urosepsis and dies.

Dr. **Rogers**. I would say delays up to 3 months if they are non-service-connected, but category A veterans may not be able to get in.

Ms. **Bishop**. Delays in West Los Angeles are in days, not months.

Ms. **Coulter**. Delays in Boston are 2 weeks to a month.

Chairman **Cranston**. Ms. Bishop, would you repeat your response?

Ms. **Bishop**. I said delays are in days, not months, for clinic appointments.

Chairman **Cranston**. The Administrator said that everybody has to wait to get an appointment, but I don't know very many people in private life who have to wait 6 months to get an appointment.

Dr. Musser, is your facility experiencing any delays in admitting veterans to the hospital for nonemergency inpatient care?

Dr. **Musser**. Yes.

Chairman **Cranston**. What is the cause of those delays?

Dr. **Musser**. The causes are primarily the size of the operating suite in the facility, anesthesiology services, lack of funds for prosthetic devices, for instance, for total hip replacements; those are being delayed until fiscal year 1989.

Chairman **Cranston**. How long are those delays?

Dr. **Musser**. We will delay total joint replacements into October through November and December.

Chairman **Cranston**. Starting from when?

Dr. **Musser**. Starting the beginning of the fourth quarter of fiscal year 1988.

Chairman **Cranston**. July 1, in other words?

Dr. **Musser**. Right.

Chairman **Cranston**. Let me ask this generally. Are delays in nonemergency admissions being experienced at any of the other VA hospitals that you represent?

Dr. **Rogers**. Yes, sir.

Chairman **Cranston**. Indicate yes or no, and how long.

Mr. **Hawkins**. Yes, anywhere from 2 weeks to 60 days.

Mr. **Goff**. Yes, in Boise, we are rationing the total joints. We already have all of fiscal year 1989 booked.

Mr. **Farsetta**. I would say delays depend upon the area in the clinic.

Chairman **Cranston**. It seems to be a general situation. Dr. Newcomb, is surgery being postponed or cancelled at the Durham VA Medical Center?

Dr. **Newcomb**. Yes, it is.

Chairman **Cranston**. Could you give us some details? What is the extent of the problem and its cause?

Dr. **Newcomb**. The apparent list of procedures yet to be scheduled is 210; this is in a variety of specialties, but most remarkable in general surgery, orthopedics, and urology. By and large, elective cases also—some of these relatively elective—in the sense that they shouldn't wait too long; but they can wait a while.

Let me go back. My figures are broken down, and I would like to aggregate them and give you a single answer to that question. It is a regular phenomenon, but there is a variety of reasons. I think on the average cancellations would average about three per week.

Chairman **Cranston**. Is that greater than 2 years ago?

Dr. **Newcomb**. Yes, it is.

Chairman **Cranston**. Could I ask each of you this question? Are there delays in surgery at your hospitals and, if so, the reasons therefor?

Mr. **Farsetta**. The answer is yes. The primary reason is the inability of the VA to pay a competitive salary for a subspecialist.

Chairman **Cranston**. Mr. Goff?

Mr. **Goff**. Yes, for the reasons previously stated.

Mr. **Hawkins**. Yes, because of operating room limits and shortage of surgeons.

Mr. **Johnson**. Yes, primarily in areas like orthopedics, where there are prosthetics and joint replacements required.

Chairman **Cranston**. Dr. Musser?

Dr. **Musser**. Yes, funds, staff, and number of operating rooms.

Dr. **Newcomb**. Yes, primarily because of nurse staffing in intensive care units and the OR, after hours particularly.

Chairman **Cranston**. Dr. Rogers?

Dr. **Rogers**. Yes, due to the lack of physicians, lack of nurses, and lack of funding for the prostheses.

Chairman **Cranston**. Ms. Bishop?

Ms. **Bishop**. Yes, related to lack of surgeons, shortage of nurses, and also anesthesiologists.

Ms. **Coulter**. Yes, for the same reasons—lack of surgeons, anesthesiologists, and nursing.

Chairman **Cranston**. Are any of you not experiencing a shortage of nurses?

Mr. **Farsetta**. I would like to answer that question. That is relative. I think that Brooklyn's experience with recruiting nurses is vastly different than the rest of the people at the table. My vacancy rate now is about 6 percent; but I will say that, looking at the budget next year, I have not recruited for nurses in about the last 2 months, and my budget is sufficiently short next year that I will probably have about 60 to 70 vacancies because I can't afford to fill them.

Chairman **Cranston**. Unless you say otherwise, I am assuming you are all short of nurses—the rest of you.

Dr. **Musser**. Senator, we need to emphasize that there are a great many of us who are especially short of intensive care nurses.

Chairman **Cranston**. Ms. Bishop, I understand that several hospitals in Region VI are considering a pilot program whereby salaries of nurses would be indexed to hospitals in the community. Would you describe that for the record in writing—not now verbally?

Ms. **Bishop**. All right.

[Subsequently, the Veterans' Administration furnished the following information:]

The current method for providing basic pay for VA nurses in amounts competitive with community rates is by requesting special salary rates. VA Central Office has the authority to approve, disapprove or modify these requests. However, this system is reactive and in most cases leads to a loss of nurses before salary increases are received. In addition, salary increases cannot exceed the 19th step of a grade. This has led to newly hired nurses receiving the same rate of pay as nurses with several years of VA service.

Indexing nurse salaries to salaries paid by the affiliated university of other index hospitals may well be a method to resolve the problem of VA nurse salary rates lagging behind community rates. Indexing would allow VA nurse salary rates to change automatically as the rates of the index facility changes. The success of the indexing method will be entirely dependent upon the cooperation of the index hospital in providing required salary data. If a cooperative relationship cannot be established with the index hospital, it will be necessary to modify and simplify the current system of obtaining special salary rates which would need to include waiving the statutory pay scale.

Ms. BISHOP. What the problem is with special salary rates at this time is not only the delay in getting approval, but the rates in the community exceed what the statutory pay table will allow. A mechanism in order for this not to occur and in order for us to keep the nurses that we so desperately need, we would index with a hospital that we felt was appropriate; and when their salaries would increase, we would be aware of that, and we would be able to move at the same rate that the community moves, and would not fall behind.

Chairman CRANSTON. Thank you. Ms. Coulter and Ms. Bishop, is the assigned nurse ceiling at your facilities sufficient to maintain adequate patient care?

Ms. BISHOP. I hate to tell you this. I am going to lose 117 positions before October 1. I am concerned that, in some areas, the workload will obviously be increased. I have complaints now about workload.

We are trying very desperately not to close any inpatient wards, and we are willing to try to do that; but it may end up that way if the nurses can't maintain the workload.

Chairman CRANSTON. Ms. Coulter?

Ms. COULTER. If we opened all the beds in the medical center, we would need to increase the rate we have now, based on workload.

Chairman CRANSTON. How many more authorized positions do you estimate each of you need?

Ms. COULTER. I think, for my total nursing staff at the present time, I have 528 individuals. So, I would have to go out beyond the 600 mark if we were to open all the beds.

Ms. BISHOP. I would think that if I could be at my authorized ceiling, which I am soon to lose, of 707, I would be doing OK—736, excuse me.

Chairman CRANSTON. You are losing 117 beginning October 1?

Ms. BISHOP. Before October 1. October 1, I understand that there is another decrease in store for me because of funding problems.

Chairman CRANSTON. Do any other members of the panel want to comment on the assigned nurse ceilings?

Dr. ROGERS. I would like to say that our affordable ceiling is low and prevents us from taking all the patients in that we should be taking in; but it is not only nursing. That is part of the problem, but part of it is the support staff for the nursing.

And with the budgetary freezes and the other problems, we don't have the administrative and the pharmacy staffs and so forth so that those few nurses who are there are then doing non-nursing activities in addition to their own.

Chairman CRANSTON. Yes, Dr. Newcomb?

Dr. NEWCOMB. I wanted to correct one figure I gave you—three per week on the cancellations. There have been 179 over a 5-month period, averaging out to nine per week. However, in recent months, there has been a steady increase so that these would be somewhat higher now; but there is a multiplicity of reasons for this.

Chairman CRANSTON. Thank you. Back to Ms. Coulter and Ms. Bishop. The chart displayed earlier in today's hearings depicts a slight increase in the employment of nurses. Has the acuity of the patients' needs increased at the same rate or at a faster rate?

Ms. COULTER. The acuity of patient needs is increasing at a faster rate; the workloads are very heavy.

Chairman CRANSTON. Do you concur?

Ms. BISHOP. Yes, I do; and besides, there has been increased technology requiring a higher level of individual in order to interpret data that are provided.

Chairman CRANSTON. I would like to address this question to Mr. Goff and Mr. Johnson. I understand that both of your facilities were selected to take part in a management efficiency pilot program. Do you believe that the flexibility you have been given as a part of that program at Indianapolis and at Boise has better equipped you to respond to the current funding problems?

If you would reply very briefly and then provide a written response for the record, I would appreciate it.

[Written responses appear in questions and answers in the appendix.]

Mr. JOHNSON. My answer would be yes to that. I had commented briefly before that this provided an opportunity during this very tight budget situation in fiscal year 1988, to take non-VA workload funding that we viewed as savings and through efficiencies, and reprogram something over $300,000 into direct patient care.

I think that was a very good example of being able to adjust with some flexibility. The other thing it does, and we really need to be aware of it is that it creates an organizational enthusiasm to deal with the number of problems we have, identify reports that probably aren't necessary, and challenge whether these kinds of paperwork activities are really needed.

We started a program as part of the management efficiency pilot in Indianapolis called "Bureaucracy Busters". We have tried very hard to get our employees to look at some of the regulations, be they local or above the hospital level, and challenge those and try to be as effective and productive as possible in meeting our responsibilities.

Mr. GOFF. There is no question that it has been a help in addressing the budget problems at Boise. All the things that Mr. Johnson just said apply to us equally as well. The employees feel now they can make a difference.

We have the ability and the incentive to move dollars to use them as wisely as possible to do those things in-house that can be done in-house more economically and don't have the perverse incentives to sometimes do them elsewhere because the money is over there, but it isn't over here.

We now can allocate beds, open and close them as needed, which is a big help. We are working on a prime vendor contract. They have removed the fourth quarter spending restrictions.

There are a number of things that we don't have to contend with now that help us manage more sensibly, and it has been a help.

Chairman CRANSTON. Even with that flexibility, however, both of you agreed earlier that you have a crisis.

Mr. GOFF. Yes, sir. It doesn't help to have flexibility if you don't have anything to be flexible with.

Chairman CRANSTON. Mr. Goff, is it true that notice was given to category B and C veterans, using the Boise VA Medical Center, that health care could no longer be provided because of a lack of resources and that this policy later was reversed at the direction of the Central Office?

Mr. GOFF. That is not entirely true. It is category C only that we addressed, outpatient care only; and the policy was not reversed. We are no longer scheduling appointments for category C veterans. If they walk in, we screen them to make sure that they don't need acute care; and if they don't need that, then we do not reappoint them.

Chairman CRANSTON. You got no direction on that from the Central Office?

Mr. GOFF. Central Office asked us what we were doing because there was a mixed message that got sent through some of the service organizations. But what we are doing is basically limiting care to some of those who are eligible but not entitled; and it is category C only.

Chairman CRANSTON. I assume that most or all of you have read the task force report. Do you expect that any of the 86 options that are described in it will be implemented in your medical centers?

[Chorus of ayes.]

Chairman CRANSTON. On your own initiative?

[Chorus of ayes.]

Chairman CRANSTON. Could each of you again, and very, very briefly please, describe those options from the report that you believe are most feasible to implement in your regions and those that will be most disruptive and harmful? If you wish to restrict yourselves to the top 18 or so, that would be fine. I don't know how you are going to do that with the time restraints we have.

Perhaps you could respond in writing to that. We will give you the question in writing for your guidance.

Do you believe that these options should be implemented nationally or that regional directors or even facility directors should be given discretion as to which, among an approved list of options, should be implemented?

Mr. GOFF. Do you want us to respond right now?

Chairman CRANSTON. Generally speaking—not getting into each one—should these be implemented nationally or should regional directors or even facility directors be given discretion as to which, among an approved list of options, should be implemented?

Mr. Goff. I would like to address that, Mr. Chairman, because I have strong feelings about it. Having had a short budget for the 8½ years I have been at Boise, I have tried different things over the years. Because I was the only one doing it and it was local discretion, it always comes back to haunt you.

I believe that we have to do these things across the board, and it has to be a national policy. If you give a series of options to directors about where they can make cuts and then let each one do his/her thing, you will find one hospital not providing over-the-counter drugs, another one not paying beneficiary travel, and another one cutting back on community nursing home care; and it won't be consistent because people will pick and choose different places to save. The veterans will then say: I can get it across the street; why can't I get it here?

So, I think it has to be a national policy.

Chairman Cranston. Yes. Any other comments along those lines?

Mr. Hawkins. Mr. Chairman, I think that report has not been distributed officially to the field; and most have only seen pieces of it. But I would be deeply concerned over the inability not to pursue buying state-of-the-art equipment and also the maintaining of our facilities. I would agree with my colleague that a decision should be nationwide as opposed to local.

Chairman Cranston. There are copies on the press table over there that you can pick up, if you haven't seen it already. Finally, I had planned to do this—and Frank Murkowski already did it—but I wanted to do it also.

Please provide in writing any other suggestions that you have that are not in the task force report, that you feel would help offset the 1989 shortfall and be constructive in any other sense.

I thank you very much for your testimony. I am sorry I took so long with you, but you have been very, very helpful and very courageous. I thank you very, very much. Thank you all.

We will now hear from a distinguished panel representing the Veterans' Administration. I want now to welcome more formally than before the Honorable Thomas K. Turnage, Administrator of Veterans' Affairs, Veterans' Administration, accompanied by Dr. John Gronvall, Chief Medical Director, Department of Medicine and Surgery; Dr. Daniel Winship, Associate Deputy Chief Medical Director; Mr. Gary Cole, Deputy Director, Department of Budget and Finance; and Donald L. Ivers, General Counsel.

I greet each of you. I thank you for taking so much time out of your busy schedules to be with us throughout the hearing today, and I do want to swear you in, as we have been doing with the other witnesses.

[Whereupon, the witnesses were duly sworn.]

Chairman Cranston. Tom, if you want to proceed with your opening statement?

STATEMENT OF THOMAS K. TURNAGE, ADMINISTRATOR OF VETERANS' AFFAIRS, VETERANS' ADMINISTRATION, ACCOMPANIED BY DR. JOHN GRONVALL, CHIEF MEDICAL DIRECTOR, DEPARTMENT OF MEDICINE AND SURGERY; DR. DANIEL WINSHIP, ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR; GARY COLE, DIRECTOR, BUDGET SERVICE; AND DONALD L. IVERS, GENERAL COUNSEL

Mr. TURNAGE. Yes. Chairman Cranston and members of the Senate Veterans' Affairs Committee, I am pleased to appear before you today to testify on the current status of funding within the medical care system of the Veterans' Administration.

I would like to take this opportunity to thank the members of this committee, especially you, Mr. Chairman, and the ranking minority member, Senator Murkowski, for your continuing support of our Nation's veterans and the VA employees who serve them. I look forward, of course, to working closely with this committee on a continuing basis to ensure that we provide the support to the Nation's veterans which they have earned.

With me today at the witness table are Dr. John Gronvall, Chief Medical Director, and Mr. Gary Cole, Director of the Budget Service. I would request that my written statement be included in the record.

Administering the largest health-care system in the world has always been a great challenge. Today, it is particularly difficult in view of the constrained resources affecting all medical systems, the private sector, as well as Government.

Moreover, equally impacting is the fact that new methods of delivering quality health-care are evolving. Advancement in medical technology and more treatment in outpatient environments require changes in the allocation of resources from traditional patterns.

These factors, combined with the critical nationwide shortage of nurses and significant localized competition for other health-care professionals, dictate that the use of resources appropriated to the VA be monitored more closely than ever before. We must ensure that resource problems are anticipated, identified when they occur, and solutions implemented to avoid any negative impact on the quality of care for our Nation's veterans.

In this regard, I believe that the VA is providing quality care. I am extremely proud of the Chief Medical Director and the personnel of the Department of Medicine and Surgery overall for the excellence that they are achieving.

To ensure that quality of care, we monitor very closely the primary indicators of the system with monthly reports. I have included several of these reports which address the disposition of applicants for medical care and selected operational indicators reflecting the current status of the system within my written statement.

Public Law 99-272 created a priority system for the delivery of health-care to veterans by establishing health-care categories which identify those veterans to whom the VA shall provide care—category A—and categories of veterans to whom the VA may provide care, depending upon the availability of resources—for categories B and C.

As a result of that law, we developed a system to account for every veteran who applied for care. The reports from that system, which are included with my written statement, indicated that we have not turned away any veterans whose care is mandated by Congress.

Additionally, the overwhelming majority of veterans in the "may" categories who applied for care and who meet the requirements established by the Congress were also provided quality medical care consistent with their needs.

Now, I would like to make a parenthetic remark about that. Two and a half years ago when I came into this system, there were allegations going throughout the press and otherwise about the fact that 30,000 veterans were being turned away from care every month. As a matter of fact, there was one noted, celebrated article that came out: "He died for lack of a bed."

I went to the source, and I said: Identify who "he" was, where it happened, when it occurred; and let me take action. Also, give me the names of 30,000 veterans who are being turned away every month; and I have not received any names, sir.

Moreover, I find it rather appalling to come into this environment now and, for the first time hear that we have a list of names of people who are category A who have not received care, because, if they needed that care—had they told me—we would have taken care of it a long time ago.

Chairman CRANSTON. Could I just ask a question on that point? We heard from all the people in the room that there are veterans being turned away—not forever, but being turned away—for substantial periods of time, like 6 months.

Mr. TURNAGE. Mr. Chairman, I understand, based on the situation with my own personal family, that if you go to get an appointment with a private sector doctor these days, you may not get it today or tomorrow; you also may have waiting periods.

Chairman CRANSTON. Not as much as 6 months.

Mr. TURNAGE. Some may be delayed; I grant that. But there is a difference between delay and turned away, in my judgment. Each month, we monitor selected activities in the medical system in order to identify trends and particular workload problems from the system level.

Included with my written statement are selected charts which reflect, from the system perspective, the application, the average daily census and occupancy rate, and levels of outpatient activity within the VA system. Those charts show that the system has been relatively stable over the past 2 years.

There are indicators of some changes in our workload from inpatient care to outpatient as the number of patients treated continues to climb, and the average daily inpatient census continues to decrease. This decrease is the reflection of the shorter lengths of stay and the impact of medical advances in the treatment of certain complex illnesses and is entirely consistent with the trends that occur in the private sector.

However, this reduced inpatient census should not be seen as a reflection of decreasing overall needs within the system because the patients we care for are more likely to require more complex medical care than the general population.

In recent days, there has been considerable controversy created in the media and other circles regarding nurses and bed levels in the VA; and I will discuss these issues briefly, and I am prepared to provide additional details later, as desired.

First, if I may address the nursing situation. In October 1986, in response to what the VA, the Congress, and the health-care industry foresaw as an impending national shortage in nurses, we initiated a survey of our health-care professional staff. This survey was replicated in 1987, and it provided valuable information upon which to develop Agency plans to meet future staffing channels.

The survey results determined that, although there is a nationwide shortage in registered nurses of over 11 percent, as stated in the recent HHS report on the nursing shortage, the shortage in the VA is approximately 4.6 percent. A chart shown earlier—and it is to your rear now—shows the level of nurses within the VA health-care system; and as noted, the total number of those nurses has remained fairly constant, with the number of registered nurses increasing.

Even in the face of the national shortage——

Chairman CRANSTON. Tom, may I interrupt for a moment?

Mr. TURNAGE. Yes, sir.

Chairman CRANSTON. I have to say that regretfully there is a roll call on. It is going to be followed by two more roll calls, but we are not going to stop the hearing because this will be in the record. We will study the record, and our two assistants will be here; and they will carry on with questions that we intended to ask until we get back.

Mr. TURNAGE. All right.

Chairman CRANSTON. They will be watching the time and dividing it equally between the two sides of the table. My apologies, but we will return.

Mr. TURNAGE. All right.

Senator MURKOWSKI. I would appreciate that, Mr. Chairman, and I would ask that, as you have indicated, that the time be equal.

Chairman CRANSTON. It will be.

Senator MURKOWSKI. All right. We will be back.

Mr. TURNAGE. Shall I continue?

Mr. STEINBERG. Please.

Mr. TURNAGE. As noted, the total number of nurses has remained fairly constant, with the number of registered nurses increasing, even in the face of a national shortage. It is apparent that the overall level of nurse staffing within the VA compares very favorably with the situation found in the rest of the industry.

Even so, we recognize that there are local and regional staff distribution anomalies that we need to address. Understandably, the urban areas pose the greatest problem and are subject to the keenest competition for personnel available.

The Chief Medical Director's sensitivity to that issue was validated by a visit of the House Veterans' Affairs Committee staff to 16 VA medical centers last spring, and the resulting report on nursing staff levels. These sites—less than 10 percent of the medical centers in the system—were receiving over 44 percent of the special pay for nurses at the time of those visits.

We had identified the recruiting and retention difficulties at these stations and have taken corrective action, and we will continue to monitor the critical field on a continuing basis.

There is one thing that should be noted, that has not been emphasized in my judgment this morning, as profoundly as I would like to do it now. Notwithstanding the number and level of nurses within the system and the constancy about that situation, the fact is that we are vitally advised of the critical nature of shortages in some areas, particularly the urban areas; and it is odd.

For example, in the greater New York area, in Manhattan, critical care nurses, intensive care nurses, nurses overall in Manhattan, is just horrendous. If you go to Brooklyn, however, as testified by Mr. Farsetta, he has 94 percent; and at the time of my recent visit, he said he had from 95 to 98 percent of his authorized nurses.

So, it is not a standard thing throughout the country; and I found that by my visits extensively to hospitals throughout the system.

Now, about beds. As you can see on this chart also, which is reflected in the rear, VA bed levels have declined since 1976, with the steepest decline between 1977 and 1981. Since 1981, there has been a gradual decline as the demand for beds has decreased. This overlay, for example, demonstrates the average daily census compared to the bed level over the same period of time.

Clearly, the number of veterans in our medical center beds has declined at a faster rate than has been the bed declamation. The bottom line, it seems to me, is the fact that the data suggest that overall, even if we had twice the number of beds, we would have no increase in the number of veteran inpatients treated by the VA.

It is important to note that, if one adds the number of beds available for service, which includes nursing home capacities, and the number of beds temporarily out of service because of renovation or construction or similar activities, we still exceed the 90,000 number that has been dictated by the Congress.

Now, as far as the current status of medical care funds is concerned, things are tight; and I have full realization of that fact. And I have sought and I have received repeated assurance that we will continue to deliver quality care to all entitled veterans this fiscal year without exceeding our appropriation.

I have not attempted to minimize the challenges we face, but neither have I resorted to hyperbole or emotion or anecdotes or negativism as a means to solve what I consider to be highly complex management problems.

My assurance that we will continue to deliver quality care to all category A veterans this fiscal year without exceeding our appropriation is derived from visits to 64 medical centers on my own; it is not from anecdotes from others; discussions with patients, staff, and directors; observation of physical plant standards; and opinions of senior medical officials supported by definitive patient data.

We have better data now since the means test and since our enhanced DHCP computer operation in the last 2½ years than we have ever had in the history of this system; and this is not a Turnage initiative. It was going on before I got there, but it started along with the means test on July 1, 1986.

As a matter of fact, this year, regardless of all the rhetoric this morning, we have $422 million more than last year; and at the end of July—10 months into this fiscal year—the medical care appropriation was underplanned by $1 million against the planned expenditures of $8.4 billion.

At the same point last year, the medical care account was underplanned by approximately $75 million against planned expenditures of $7.9 billion. We are running much closer to plan this year. We have obligated approximately $190.6 million toward the replacement of additional equipment, as compared to $191.6 million last year; and we have obligated approximately $20 million more in lands and structures replacements or additions over fiscal year 1987.

We have some real challenges, but we are attempting to manage in such a way that we can guarantee the future viability of the system. We do have problems in the equitable distribution of resources in individual medical centers and to adjusting quickly to changing requirements in the field.

We are wrestling with the difficulties of financial systems which are antiquated and which no longer can provide needed management information in a timely manner. We have initiated a program to update these systems, to provide our managers with the tools needed to operate in the current environment and into the future.

We are attempting—and here is part of the problem of perception—to move resources from areas that are serving a declining number of veterans into areas of increasing demand. These shifts, I am sure, are perceived as budget cuts to those facilities that lose funds; and obviously, they have led the cries that VA funding has been reduced overall, which is not true.

In reality, the shifts were simply an attempt to reallocate resources to those areas of greatest needs.

Now, this morning, Senator Graham came and made the plea that in Florida their population of veterans is increasing by a substantial amount of people each month—5,000 a month. Obviously, then that creates greater difficulties not only in Florida, but also the entire Sunbelt.

But the concomitant of that is also a reduction for requirement of services in other parts of the country where those people leave. So, when you change the allocation process, you hear cries from one part of it; and you hear applause from the other. You can't please them all.

We face some real constraints on the efficient management of resources from certain provisions of the law. For example, in fiscal year 1987, approximately $70 million lapsed in the medical care account, due in part to the arbitrary floor on personnel services dollars included in the appropriations language.

We have, as a matter of long standing—and I think this is critical, where you could be of great assistance to us—contracted for certain health specialists when it was to the advantage of the Agency or when hiring difficulties precluded hiring the required staff. However, we don't get FTEE or dollar credit for these contract personnel under the current law, and we are required to expend funds to meet an arbitrary floor on FTEE even though we believe those funds could be better used elsewhere in the medical-care system.

This fiscal year, approximately 2,224 FTEE and $138 million were involved in that process.

Additionally, when the Congress mandates services and benefits without supporting appropriations, we face real management challenges. The passage of Public Law 100-322 that went into effect on July 1 was responsible for much of the recent churning in our system, as DM&S had to reallocate its resources to support the new mandates.

From the perspective of the Agency, however, I am convinced that this year, within available resources, we will continue to deliver quality care to all veterans whose care is mandated by this body and that it will be done with concern for the future viability of the VA health-care system.

It is my deeply held conviction moreover that false impressions generated by unfounded assertions of inadequate quality of care or denial of care to entitled veterans can only inure to the disadvantage of veterans in the long term also, to the Veterans' Administration.

The primary responsibility for the operation of the health-care system rests with the Chief Medical Director; and with your approval, I would ask Dr. Gronvall to present his assessment because our comments, I think, are complementary.

[The prepared statement of Mr. Turnage appears on p. 321.]

Mr. STEINBERG. If you would withhold for a moment, please, Dr. Gronvall? First of all, we would ask you to please restrict your summary to 5 minutes. We allowed the Administrator 13 minutes, and we do have a substantial number of questions we want to ask.

I just have two brief comments, Mr. Administrator, to share with you. One is: You may have noticed that we did not have witnesses from the Sunbelt here. We did not selectively try to pick witnesses from one particular area of the country that was in an increased demand situation.

Second, you referred several times in the course of your testimony this morning to the $420 million—and it is actually $424 million—by which your 1988 budget exceeded your 1987 budget, or actually your appropriation exceeded your 1987 appropriation. Do you know how much of that was due to a congressional add-on?

Mr. TURNAGE. Not precisely, but I think Mr. Cole can probably give us that information, sir.

Mr. COLE. I don't know——

Mr. STEINBERG. I think that it is $244 million. In other words, it is close to two-thirds of that increase that was provided by Congress over the budget request.

Mr. COLE. Yes.

Mr. TURNAGE. The source notwithstanding, we are delighted to have it.

Mr. STEINBERG. We were glad to be of assistance in providing it. Dr. Gronvall, if you would please proceed now to summarize your statement?

Dr. GRONVALL. I have the specific figure if your question was about the fiscal year 1988 appropriation.

Mr. STEINBERG. My information is that the amount was $10.152 billion, as compared with $9.728 billion for fiscal year 1987.

Dr. GRONVALL. Excuse me. I thought you were talking about 1988.

Mr. STEINBERG. Would you proceed now, Dr. Gronvall, please?

Dr. GRONVALL. Yes, thank you very much. I am pleased to make some summary remarks. I would ask that the full written statement that we have submitted be a part of the record.

Mr. STEINBERG. It will be, of course.

Dr. GRONVALL. And what I will attempt to do is to pick out of a long written statement first a kind of brief frame of reference within which, I think, we can best understand what the present status of the Department of Medicine and Surgery is.

That overall frame of reference, in a sense, has been referred to by all of the witnesses today, who have pointed to a long period of years of an accumulating discrepancy between the extent of the work demanded of the Department and accomplished by the Department and the specific resources available.

That has been portrayed in relation to the budget in a series of charts. Our written statement provides the detailed information for this past decade, a decade that I think could best be characterized as a decade of cost consciousness. During that decade, starting with 1979, as our statement shows, the Department of Medicine and Surgery has increased the number of veterans that we have admitted to our hospitals, along with those admitted to our nursing homes, domiciliaries and our contract programs.

We have during that time also remarkably expanded our outpatient care system. All of that has been then reflected through shortening of length of stay, with a declining census. That chart is displayed now, and I want to be sure that there is no misunderstanding in the audience because that declining blue line is the decline in the census, namely the number of patients on any one day hospitalized in our hospitals; but in fact the aggregate number of patients admitted, diagnosed, treated, and discharged each year has continued to go up.

During this period of a decade of expanding work accomplishment, again as has been shown, the VA's medical care budget has been essentially level when it is viewed in terms of its purchasing power by taking inflation into account.

We have been fortunate by being able to compare the VA as a system with the remainder of the private hospital system of the Nation, based on data from the American Hospital Association, coming from some 5,600 community hospitals—the so-called private sector of hospitals.

Again, the details are in our written statement; but I can summarize that, if you look at the comparison during recent years, the actual number of patients treated in the community hospital sector has been declining. The number of outpatient visits has been increasing as has been the case in the VA; but when you make a comparison in terms of the aggregate costs in the private sector, in spite of a decline in the number of patients treated in the hospitals, there has been something like a 20 percent real increase in the aggregate cost or expense of operating that system.

So, in comparison, I would say that it appears to me that the accomplishment of the Department of Medicine and Surgery is one that should be applauded for having expanded the number of veterans we have cared for with level purchasing power; and that record, I think, is well documented and has been testified to today.

We believe that that emphasis on expanding productivity has been good public policy; but I think, as you have heard amply testified today, it has brought us to the position of the present where it is our judgment in the Department that we have essentially exhausted any internal reserve for future, significant, internal reallocations of resources or such continued accomplishments.

My statement describes the current year as a "watershed year," and it summarizes the key reasons why fiscal year 1988 has been so different from recent years in the Veterans' Administration. In spite of that, we have continued to demonstrate our ability to treat more veterans because, during this year—again in spite of all the problems that have been described here—the actual number of patients treated in our hospitals is some 4.4 percent above our operating plan.

This occurred in a year when the budget summit agreement established a clear prior mandate that no supplemental support would be sought; and on that basis, when we received our appropriation this year in 1988, we made a set of internal budget adjustments. They were difficult ones, but we gave our medical center directors their clear marching orders that their job was to operate their institutions on the basis of the funds that were available.

In July of this year, our situation was further complicated by the new Public Law, which mandated us to expand our efforts, in spite of the fact that additional resources at that time had not been made available. That created the need for a further internal reallocation; we, of course, are extraordinarily grateful that subsequent actions have produced supplemental funding to the Department on that basis.

Much testimony has been heard today on the national shortage of nurses and other critical staff. Again, we have taken many steps to try to protect our staff and recruit and retain key staff. The centerpiece of that, I think, has been again an internal reallocation; special salary or special pay agreements for all of our staff have now gotten to the level where we have internally reallocated well over $100 million to accomplish that. And that further has been a source of loss of further flexibility.

I am pleased again to note that the 1989 appropriation recognizes that need with some $45 million for special salary rates.

I can close with a capsule summary in just a minute or two. What are we doing about this? In the face of our clear recognition of this situation, we have sought to review the situation honestly and make plans for the coming year.

I have had the good fortune during recent months to have the opportunity to meet with every single VA medical center director and chief of staff in a series of regional meetings across the country. In each of those, we have had frank discussions. We have attempted honestly and fairly—and I believe that has been accomplished—to document our situation, document our projections for the next year, and more importantly to seek the advice of not only our officials in the Central Office but people across the entire system regarding steps that we might be able to take for next year that would make our program commitments better match our projection of the funds that we will have available.

There has been comment today on the nearly 100 items that were suggested as a result of that elaborate process. Those have been pared down to a prioritized recommendation by an excellent task force. That shorter list of recommendations is now undergoing intensive review; and we intend to take intelligent, well-informed action before fiscal year 1989 starts to ensure that we enter the year with a sound projection that matches our program commitments with our resources.

In closing again, in a sentence, I would just say that our commitment to deliver quality care remains unaltered. I have regularly testified to the Congress when we have appeared to testify on the President's budget or on other occasions that quality of care is our fundamental objective and that, if factors of support or resource availability or distribution of our facilities or other national problems caused adjustment in the quantity of care, we would take those steps, but protect the quality of the care that we would give, consistent with the statutory responsibilities that we have.

I thank the dedicated staff of the Department, many of whom have been here today. Many of those specific individuals who have testified today, in fact, have been key figures in this intensive review that has gone on during recent months as we ourselves within the Department have sought to ensure that we would have the benefit of the very best advice from our most thoughtful people about steps that we can take not only this year, but moving ahead into next year.

With that, again, I would be pleased to respond to additional comments or questions.

[The prepared statement of Dr. Gronvall appears on p. 343.]

Mr. **Steinberg**. Thank you very much for your testimony, Dr. Gronvall. On page 1 of the task force report, it is indicated that, based on the administration requested budget—not the appropriated budget, but the requested budget—an $819 million shortfall exists. Do you agree with the task force estimate?

Dr. **Gronvall**. I agree that, at the time that that figure was used—and it was used some couple of months ago as a starting point for this serious internal planning effort—it was a valid figure at that time. It was our best effort to document at that time, based on the information available then and projected forward what might be termed a shortfall.

Mr. **Steinberg**. In view of the $215 million add-on to that amount, what is your current estimate of the shortfall?

Dr. **Gronvall**. Since that earlier figure was developed, of course, a number of things have occurred. The appropriation has been made, and so we have updated our estimate on the basis of the additional funds received in the appropriation.

You are right in pointing out that the appropriation was some $215 million above the request; however, a number of items that are in the appropriation are to support either new activities or new levels of staff or support programs that had not been included in the earlier problem list.

So, it is not possible to just take that money and say it reduces that list.

Mr. **Steinberg**. What is the figure now?

Dr. **Gronvall**. I think I need to explain the context of how we moved from that to a figure which I will shortly give you. In a similar fashion, as we have moved through the past months, we have made some internal decisions not to do some things next year or found some ways to make internal adjustments. By the time you add all of those pluses and minuses together, our current estimate of a similar accurate figure for today is some $608 million.

Mr. **Steinberg**. Would you be able to provide for the record what the component parts are of that $608 million, please, in writing?

Dr. **Gronvall**. Yes, sir.

[Subsequently, the Veterans' Administration furnished the following information:]

MEDICAL CARE DETAIL OF ESTIMATED SHORTFALL

The Department of Medicine and Surgery currently estimates the operating 1989 "Shortfall", including universal precautions and discretionary provisions of Public Law 100-322, to be $634,563,000. The following chart summarizes the categories contributing to this deficiency:

Category:	*Thousands*
Productivity: This level reflects shortfall generated by the prospective productivity improvements for 1988 and 1989 that have not been withdrawn on a recurring basis from the VAMCs	$98,411
Imposed savings: The budget contains projected savings for supply improvements, the DHCP program, and CALM improvements. These reductions have to be withdrawn from field operating accounts	11,050
Contract hospital: This is the current estimate of need less the funding level in the 1989 appropriation	47,207
Homeless programs: This represents the shortfall resulting from the required funding of both the Homeless Domiciliary program and the Homeless Chronically Mentally Ill program. Appropriated dollars expire in 1988 and funds to operate these programs must come from realignment of VAMC resources	23,619
Special pay: Estimate of need accumulated since the end of 1987 less the amounts appropriated in fiscal year 1988 ($40 million) and fiscal year 1989 ($45 million)	97,208
AIDS: Reflects the effect of "freezing" the budgets of those facilities identified for special AIDS support in the 1989 Appropriations Act.	12,000
Payroll: This is the unfunded costs of within-grade increases and announced increases in the Federal Employee Health Benefits program	120,029
Pay raise: This is the amount needed to fully fund the 4.1 percent payraise in January 1989	86,065
Public Law 100-322: Funds necessary for the following provisions of this new law—State Home Per Diems, Tuition Reimbursement, information and training on AIDS prevention, revised Outpatient Eligibility, Health Care Outside the US, POW DENTAL Care, Beneficiary Travel, Saturday Premium Pay, Standardization of Medical Supply items, and a Report on Contract care	[1] 113,164
Total	608,753

[1] Differs from the $117,204 estimate of cost of mandatory provisions of law by the following: −$4,700 for Readjustment Counseling which is considered to be in the 1989 appropriation and +$660 for Health Care Outside the U.S. not initially considered mandatory—$117,204 minus $4,700 plus $660 equal $113,164.

Mr. Steinberg. In view of that $608 million estimated shortfall at this point, do you believe the time has arrived when you can no longer absorb so-called productivity cuts? When you testified before

the committee on March 4, you at that point acknowledged that there was going to be a time at some point when you could no longer continue improving your productivity. Has that point arrived in view of this $608 million shortfall?

Dr. GRONVALL. My answer to the further productivity question has to do not so much with that projection of the shortfall as it does to my judgment, again, based on the kinds of evidence that has been testified to here today that we have come to the end of a period of something like a decade of making significant productivity increases; and I believe that internal flexibility has been virtually exhausted.

Obviously, there is always room for improvement. We are looking for ways to make management improvements, seek new efficiencies, et cetera, et cetera; but fundamental, major, internal further reallocations in my judgment cannot be made.

Mr. STEINBERG. The chart displayed earlier by Senator Murkowski this morning—one of the charts—shows that, although a steady rise occurs in current dollars appropriated, there is no real growth at all in terms of real dollars over the last 4 years. Is that correct?

Dr. GRONVALL. Yes, sir. And in fact, my statement portrays that in a different way over a period of a decade and documents the fact that when so adjusted, the purchasing power of the medical care appropriation has been essentially level for a period of a decade.

Mr. STEINBERG. In light of that testimony, what is your testimony about whether or not there have been increased demands for care and major new requirements placed on the Agency—such as in the area of AIDS, PTSD care, high tech diagnostic tools, quality assurance, Federal employees' health insurance, pay raises, new retirement plans—over that same period of time?

Have there in fact been substantial new demands on the Agency, both from the standpoint of those kinds of requirements as well as increased demands for care?

Dr. GRONVALL. Clearly, there have been increased demands placed on our hospital system, and you have named many of them. There are others. Some of the items that you name have been explicitly part of the increased actual dollars in the appropriation year by year.

The line of actual dollars appropriated year by year has gone up, as that chart displayed; and some of the items that you described in terms of salary increases, et cetera, et cetera, have been accomplished clearly with those additional dollars as we have gone through the years.

Mr. STEINBERG. In part.

Dr. GRONVALL. In part. But the basic answer, of course, is that the Department has faced an expanding level of demand. Eligibility for care has been expanded by the Congress, as has been pointed out; and the number of eligible veterans seeking care has continued to increase.

Mr. STEINBERG. Thank you. That is very responsive. Mr. Administrator, if I may turn to you for a moment or two to get a clarification. When you earlier were speaking with Senator DeConcini, you indicated with respect to a fiscal year 1989 supplemental, that that information was embargoed until the President's budget for fiscal year 1990 was forthcoming in January. Does that mean that there will not be any supplemental request forthcoming until that time, if ever?

Mr. TURNAGE. We don't know the answer to that question. In response to a similar question the day before yesterday at a House hearing, I pointed out to Chairman Montgomery and others there who expressed similar interests that we would do anything that we could do in order to help alleviate the problem.

I am concerned about the supplemental being acted on in January simply because of the delay time that would be incurred in the interim.

Mr. STEINBERG. We share that concern.

Mr. TURNAGE. And because of that, one of the things that has been very turbulent in the system and has real challenges for the management of DM&S is that, where you end up with supplements that come through the normal process, it is deep into the fiscal year before they know precisely what they have to work with. As a result, there is churning.

So, in order to overcome that, knowing that we have a problem for 1989, we are hoping that there will be some kind of other process that can be exercised in order to meet that problem. Part of the problem, of course, as you know, is that in the VA system our appropriation has already been passed and so forth. So, I understand that some of the flexibility has been taken away.

But you, in your expertise here on the Hill, knowing what you do about the system, if you can assist us with that in any way, we would be delighted to hear; and we would work with you.

Mr. STEINBERG. We would appreciate your assistance in that regard, which we know you attempted to provide in August, but not successfully. Following up on your response to Senator DeConcini, and what you just said now about needing the money before January, it is now the 9th of September.

Congress will be in session perhaps for another 4 weeks. The Appropriations Committees will be meeting within 2 weeks to mark up the continuing resolution, which is the last train. That suggests to me that, if you don't have an answer—an affirmative answer—from the Office of Management and Budget within a week, the steps that you indicated to Senator DeConcini that you were prepared to take should be forthcoming.

Mr. TURNAGE. We went to the OMB on September 1 with the normal supplement for the next year. Since then, our office has had contact with OMB, pointing out what we consider to be the criticality of the process. I am personally involved with that, and I recognize also the nature of the time limit imposed.

Please understand that we will do what we can to come under that umbrella.

Mr. STEINBERG. In that regard, when did you submit your fiscal year 1988 supplemental request for $25.9 million?

Mr. COLE. Some time in August.

Mr. STEINBERG. It was submitted before August.

Mr. TURNAGE. It was May, I believe.

Mr. COLE. May 25, 1988.

Mr. TURNAGE. Yes.

Mr. STEINBERG. May 25, and as of August 3, it had not been acted on. So, I am concerned about the usual OMB time frame. It actually was acted on negatively; OMB rejected it on that very day that the Senate appropriated the money, as you pointed out.

Mr. TURNAGE. Yes.

Mr. STEINBERG. So, that is, at a minimum, the normal OMB time frame, and time and delay always work in their favor. So, I would just leave that with you. We hope that you will take the steps that you indicated to Senator DeConcini in order to get it forthcoming in a timely fashion. That would be of great assistance to the Congress in responding because there is no room in the budget ceilings for additional appropriations.

A Budget Act waiver will be required and will be extremely difficult to get in the absence of a budget request. We were very fortunate in what occurred in August, and I wouldn't count on it occurring again.

In the document entitled "1989 Department Budget Appeals," the final DM&S request for medical care for 1989 was $11.036 billion for 197,604 FTEE. That document further indicates that the allowance that was approved within the Agency was $10.56 billion and 194,140 FTEE—a figure you are all very familiar with; or $476 million and 3,464 FTEE less than requested by the Chief Medical Director.

Can you tell us why you did not approve the Chief Medical Director's full request? This was the full request that he made to you internally within the Agency according to the Agency document that I have quoted from.

Mr. COLE. What fiscal year? 1989?

Mr. STEINBERG. 1989.

Mr. COLE. And your FTEE number is what?

Mr. STEINBERG. The requested number according to this document was 197,604, and the figure you went to OMB with was 194,140; and the dollar amount that was requested was $11.036 billion, and the amount that you went to OMB with was $10.560 billion. So, the discrepancy—the difference between those amounts is $476 million and 3,464 FTEE—less than the Chief Medical Director requested for DM&S.

What I am asking is: Can the Administrator tell us his reasons for not approving the Chief Medical Director's full request?

Mr. TURNAGE. That request contained a number of discretionary items, which in effect would have turned out to be nice to have, as opposed to critical to the performance of the system. And based on the economic environment in which we found ourselves, it made sense to us to go for that which was necessary as opposed to, once again, the discretionary items. That is why the decision was made.

Mr. STEINBERG. So, it was your assessment—and I will yield to Mr. Ptak in a moment—at that time that that amount was not necessary? The full amount requested was not necessary; there were items in there that you felt were discretionary and that the Agency could do without?

Mr. TURNAGE. Essentially, that is correct.

Mr. STEINBERG. Mr. Cole?

Mr. COLE. Mr. Steinberg, we have a different number here, but it is within $20 million. I have $10.58 billion requested, and 194,409. We may have amended the OMB submission after the number you received; I don't know.

Mr. Steinberg. The document that we have is an Agency document. It might be accurate, but I think the point has been answered by the Administrator.

Mr. Cole. It is essentially right.

Mr. Steinberg. Thank you. Al?

Mr. Ptak. General, first I would like to congratulate you on the fact that you have visited 64 medical facilities during your tenure. I think for you to get out and visit those facilities, with your busy schedule, says a lot about your leadership; and I commend you on that.

One thing that you mentioned in your opening statement was the peculiar problems with the Sunbelt; and in the list of witnesses, there was a doctor from Dallas, I believe, a regional director from Florida, and an individual from Atlanta. I was wondering if you could elaborate on the problems that come up with the movement of veterans to the Sunbelt?

Mr. Turnage. The central problem is that of numbers; and we find out that if you look particularly at Florida, you look at the southern parts of Georgia, Alabama, going into southern Texas, going into New Mexico, into Arizona, and southern California, you will find that there is an influx of people. But the area greatest affected is the State of Florida.

Because of the timing associated with that, the influx has exceeded really the expansion of the VA's infrastructure in that area to accommodate it. Moreover, for example, in a number of the States in the country, we have State veterans' homes programs where, in some States, it is more than one veterans' home, as opposed to some that have just one and others none.

Florida had taken no initiative to assist by having a nursing home of their own or more than one. So, the problem has been exacerbated over a long period of time; but there are a number of initiatives that are going on there now, as also I think was pointed out in the testimony, to include the provision for new hospital centers, for expanded outpatient clinics, for other adjuncts to the system, to include nursing homes and spinal cord injury systems and the development of a State veterans' home program, in order to meet that demand as it goes on.

Part of the frustration within the system has been the fact that, when you have an individual who has come from an area where there has been less demand on an existing medical center, then it means that that medical center was more prone to provide services on a resource-available or space-available basis than the individual center in Florida, where there was a very critical shortage of space and resources available.

So, as a result, the standards of responsiveness may have varied. When that occurred then, the veteran found that difficult to understand; and obviously, morale problems resulted from that. But on the other hand, the second and perhaps more critical aspect of it is the fact that, once the medical center is going in another part of the country, notwithstanding the fact that there may have been a reduced workload, it is very difficult then for anyone to understand why there is a curtailment either in the size of the staff or of services or of change of mission or curtailment of resources available.

We pointed out earlier in our testimony that, while we had a $422 million increase this fiscal year, still some medical centers had fewer dollars than they did last fiscal year; but when it shows up in a report from a local medical center in the newspapers and is picked up by UPI or someone else that the Veterans' Administration has a dollar crunch or a dollar shortage or a budget cut, it goes all over the country; and that is perception.

I have tried very strenuously to overcome that perception because all things are not bad; there are a lot of people who are doing quite well, and I still say that that is a reasonable statement.

Mr. PTAK. Thank you, sir. It has been stated recently that the VA has misled the Congress and veterans with regard to the funding situation. What is your reaction to that statement?

Mr. TURNAGE. I find it incredible. For example, here 2 days ago at the House hearings and here this morning, this committee continues to make reference to what in effect were internal documents that Dr. Gronvall had put together by a task force on his own staff in order to try to meet some of the demands and challenges associated with the system.

Yet that is taken out of context and is used here for purposes of saying, hey, this is what is wrong with the system. The point is that it is difficult for me to understand why anyone in the committees on the Hill would suggest that they don't have any information that is going on because they know everything I do and everything Dr. Gronvall does; and sometimes they know it before we do.

So, to suggest that there is a surprise is, I find, rather appalling.

Mr. PTAK. This morning, we have heard about the fact that there is a supplemental request at OMB. In your view, why is the budget situation what it is today? In your judgment, what is the cause? And it doesn't necessarily have to be within the last year or two.

Mr. TURNAGE. There are a number of causes, sir. First of all, I don't think we are in an environment particularly now where we are ever going to get all we want. I tried to put it in a perspective in my responses to Senator DeConcini, but I am not sure that the point was accepted or understood or put in the context of the whole.

I pointed out that last year—fiscal year 1987—we spent $770 million for new construction and renovation and refurbishing in this system, the biggest dollar amount in real dollars since World War II. When people talk about the fact that the system is being dismantled or the system is deteriorating and so forth, they fail to recognize that kind of fact.

Moreover, we had a separate study which was conducted last year and the year before—we just recently got reports on it—where we spent $8.5 million to have outside engineering agencies—not a parochial in-house thing, but outside engineering agencies—come in and evaluate the medical structure system within the VA. And they came back, and they had the report on 132 of the 172 VA medical centers already; and they said, the system is good, and the standards are high.

And when I go around and I look at the system, and I had 39½ years in the military; and I think I know something about standards of physical excellence. I have only been disappointed in two places, and we took corrective action on those right away. The rest of them, I think, any veteran or any individual should be very proud to go and be served in the environment in which we find ourselves.

Associated with that is the fact that right now we have an expanded number of interfaces with the services of the armed services, to include as recently as 10 days ago when I was in Albuquerque. There is a beautiful new edifice, and on the front it says: USAF/VA, where it is a joint thing, where each could not have afforded some of the amenities that are present in that operation; but collocated and jointly, we can do that.

And you know of initiatives that are going on now at Elmendorf, in Hawaii, and in Las Vegas, and a lot of other places. There are some 300 such arrangements going on, all designed to enhance the system, which goes back to something that was pointed out earlier, I think as another reflection of productivity.

So, that was one facet of the system. The second thing I tried to point out to him is that currently—right now—there is $1.6 billion in process for construction and renovation and refurbishing. All of these things, it seems to me, if you take in terms of the whole, should give pause to allegations that the system is in the kind of crisis suggested.

The problem however, which is current relates to the real reason I think, of why we are here; and that is the fact that there has been a lag time between benefits and entitlements that have been specified for veterans, and I have no issue with that, and the appropriations associated with supporting those kinds of activities.

Since, for example, the 1989 budget went in, we found out that the CDC came up with new standards with regard to the treatment or precautions relative to AIDS. We found out that there have been a number of hospital centers that came in said they needed more money, incentive money, for nurse hiring or for pharmacists or otherwise.

All of these things occurred to include Public Law 100-322, since the budget process. Obviously, then, you can appreciate why there is a lag time; and now, if we follow the normal process of waiting until January for the submission of the supplement, we will be in trouble; and it is difficult to manage under those auspices.

Mr. PTAK. Thank you, General. Dr. Gronvall, as the Chief Medical Director, do you feel comfortable with the current operating bed level?

Dr. GRONVALL. With the current total number of beds? That is not easy to answer with a short "yes." I believe that we have a small number of facilities where we do have beds closed, primarily as a result of the relative unavailability of staff, particularly nurses.

But that pattern which is displayed behind you of a progressive decline in the total number of operating beds, I feel very comfortable with. Said another way, if I had to list the major problems that we face or the major things that we need to accomplish next year, expansion of a significant number of new beds to open in our operating bed complement would not be on that list, except, as I say, for a few very specific instances where some of our medical centers do have beds closed that need to be reopened. Some of those have been testified to here today earlier.

Mr. PTAK. Let me ask that in a little bit different way. Do you think there should be a minimum bed level?

Dr. GRONVALL. I believe that the number of beds we are operating should be a derivative of the number of veterans who come to us, are medically judged to need care, and the length of time it requires to hospitalize, diagnose, and treat the veteran.

So, I think that the number of beds we are operating should be a secondary derivative rather than a primary decision made in advance of consideration of those factors. So, I think the answer to that is "no" the way you asked the question.

Mr. PTAK. I would like to ask one more quick question of both of you because my time has almost expired. Senator Murkowski has mentioned a number of times the fact that one of the ways to alleviate the funding shortage is to have new management initiatives, new flexibility.

Do any of you have any quick ideas on what you would like to see initiated?

Mr. TURNAGE. Not necessarily a new initiative, but I think less constraints imposed by the Congress of the United States. For example, the floor that is established now on people in medical care—and I think that this was brought out by a number of the people testifying here this morning—is an artificial floor, and I think its original design probably had merit; but it has worked to the disadvantage of the system.

The fact is that, a year ago, when we were trying to meet that floor, we were not hiring professionals because they weren't available; but we were hiring other people where the need wasn't there, but simply to meet an artificial requirement. And if we had the dollars but less constraints, I believe that would be of great assistance.

The second thing related to that refers to the testimony that I tried to cover about the fact that we contract for professionals, and we pay money and use equivalent FTEEs for them. That should be applied against our FTEE ceiling and personal services floor. Right now if we had that $138 million counted against the dollars floor, we would certainly feel more sanguine about the situation.

Mr. PTAK. Dr. Gronvall?

Dr. GRONVALL. You asked for a quick response. I would support strongly what the Administrator has just said and could expand that at length. In Senator Murkowski's question, he suggested, as kind of the cornerstone of looking for a new way to innovate and operate within constrained budget times, use of facilities in the private sector on a contract basis.

Our experience almost uniformly across the board over a multiyear period is that that costs more than providing the care in our own facilities, and we can provide chapter and verse in elaborate data to support that. So, that, in and of itself, is clearly not a solution.

The result of an extensive expansion of contract care would be that fewer veterans would be treated than we are now treating at higher cost than we now have available. We do make use of contract care in certain specific instances and have negotiated some very desirable contracts and make use of extensive contract care in nursing homes in particular.

My reference is to acute, inpatient hospital care where our evidence is that the private sector operates at higher cost than we do; so that would not only not be a solution, it would be a further problem for the VA.

Mr. PTAK. Thank you, Jon.

Mr. STEINBERG. Thank you, Al. Dr. Gronvall, to clarify, the Administrator said that you were not able to hire up to the ceiling with professionals because the professionals were not available. Would it not be more accurate to say that the primary reason was because the dollars were not available?

Dr. GRONVALL. It is a mix.

Mr. STEINBERG. Is it approximately a 50-50 mix? I am going to need to restrict your answering time.

Dr. GRONVALL. I can give it in a couple of sentences. We have exquisite mandates, floors and ceilings on total staff and on administrative staff and on certain categories of support staff. Dollars are a problem, but we are hamstrung regularly by having to meet arbitrary standards of certain categories of personnel that must be hired, in a sense, whether they are needed or not or whether that is the best deployment of the mix of people needed in the medical center.

Mr. STEINBERG. Mr. Administrator, in responding to Al's question earlier, you made reference to the timing problem of submitting supplementals and that developments occur. And you referred to the universal precautions of the CDC, which OSHA has mandated, and also to certain nurse special rates; and you did that in connection with submitting a 1989 request.

One would assume that you did that because indeed you have requested funding for those areas in your supplemental request. Is that an unfair inference for me to make?

Mr. TURNAGE. Are you speaking about 1989?

Mr. STEINBERG. Yes. I believe you were referring to 1989 specifically when you said that the 1989 budget was put together before the universal precautions were established.

Mr. TURNAGE. I think, based on my recollection, that is correct.

Mr. STEINBERG. Yes, I am not quarreling with you.

Mr. TURNAGE. All right.

Mr. STEINBERG. I am saying that, in mentioning that, in connection with why the 1989 budget was where it was when submitted and why there are additional needs today, it seems to be a fair inference that your request to OMB includes those two items that you referred to as examples—the universal precautions and special pay rates. Is that an unfair inference for me to draw?

Mr. TURNAGE. I am only presuming that, based on those changes that occurred since the submission of the budget, that Dr. Gronvall in his request that came to us for the supplemental would have included such provisions. I can't answer specifically; I don't know.

Mr. STEINBERG. Nor, I believe, could you answer specifically if you did know. [Laughter.]

In any event, let's both make that assumption and move on.

Mr. TURNAGE. Fair enough. Thank you.

Mr. STEINBERG. And I believe that—just to put this in the record verbally—according to the information which you were kind enough to get to us last evening, Dr. Gronvall, in response to our written request for prehearing information, the shortfall for the universal precautions is $25.8 million.

Dr. GRONVALL. Yes, that is our best judgment; and the answer that we provided includes the basis of that estimate——

Mr. STEINBERG. Yes, that is very clear. We were very interested in that; that is quite a large figure, and I don't think anybody in talking about complying with universal precautions really had a good handle on how much it would be. It was very helpful; that is a lot of money.

Dr. GRONVALL. Yes.

Mr. STEINBERG. Let me move on to one other clarification with respect to the shortfall that we have talked about, as I understand it, we are talking about a lack of funding in order to maintain the current level of services to meet your present demand for services and to carry out certain requirements of law. Is that a fair estimate of what the shortfall is, that is, describing what the $608 million means?

Dr. GRONVALL. Correct. It takes the present operation, projects it through the next year, adds into it all of the stipulations of the Appropriations Act, the mandate for salary improvement, the requirements for the new legislation, and attempts as directly as we can to translate that to a full year's cost experience, and then compares that with the appropriation that we have received to date for the fiscal year 1989.

Mr. STEINBERG. Exactly. And as Senator DeConcini pointed out, according to the information you have provided us, the cost of Public Law 100-322 is approximately $117 million in fiscal year 1989 as to the entitlements.

Dr. GRONVALL. That is the cost of the mandatory components of that act. Yes, sir.

Mr. STEINBERG. Right, and the amount of the shortfall is somewhat short of six times that amount. Is that correct—$608 million?

Dr. GRONVALL. Correct.

Mr. STEINBERG. Just slightly short of that. Thank you. Mr. Administrator, when you submitted your budget request for 1989, did you then consider it adequate to carry out the VA's goal—and I am going to quote now from your annual report, your articulation of the goal: "Providing quality medical care on a timely basis to all eligible veterans."

Mr. TURNAGE. If you are quoting, then it sounds as if I said that.

Mr. STEINBERG. That was your goal.

Mr. TURNAGE. However, I have no contest with it. Yes.

Mr. STEINBERG. All right. Today, on the 9th of September as we sit here, do you think that the 1989 appropriation for medical care, which as Dr. Gronvall and you have both pointed out, is $215 million more than the budget requested in February, do you believe today that that appropriation is adequate to carry out that goal of "providing quality medical care on a timely basis to all eligible veterans"?

Mr. TURNAGE. It goes back to the question of eligibility.

Mr. STEINBERG. I know.

Mr. TURNAGE. I thought you might; but what you are talking about here, and that is part of the issue that we have been discussing with Dr. Gronvall and part of the options that he has been considering in order to meet the requirements, consistent with the budgetary process, is first of all based on the information that I have provided in my testimony this morning.

Up to this time, we have provided quality care to all category A veterans. We have provided quality care to almost—to our knowledge, with certain exceptions—all of category B and C veterans around the country; and that, as you know, is not a "shall"; it is a "may."

Mr. STEINBERG. Absolutely, but they are eligible.

Mr. TURNAGE. All right, but once again, the business of "you will," as opposed to "you may." So, then, that is part of the ultimate decision here as to what process will be followed in fiscal year 1989.

Mr. STEINBERG. You can't do what your resources don't permit you to do.

Mr. TURNAGE. Precisely.

Mr. STEINBERG. And we understand.

Mr. TURNAGE. I want to endorse one thing that Dr. Gronvall said. There will be no compromise of the quality.

Mr. STEINBERG. And what has been illustrated, I think, is that the notion of eligible veterans has to flow with the flow of dollars.

Mr. TURNAGE. Yes, sir. And the fact is, and I would like to point out, that you people here make the definition of eligibility. We administer that within the policy that you establish.

Mr. STEINBERG. Fair enough. Do you differ from Dr. Gronvall's figure, which you just heard him clarify and explain, that the current appropriation for 1989 is $608 million short of enabling the Agency to continue with its current workloads and to comply with regulatory and statutory requirements?

Mr. TURNAGE. I don't know that I agree with that; and before I would respond, I think I would prefer—with your indulgence—to provide an answer for the record.

Mr. STEINBERG. Certainly.

Mr. TURNAGE. I would like to look into that more.

Mr. STEINBERG. That would be fine and would be very helpful. I am sure Dr. Gronvall would be glad to see that as well. And could you, when you provide that answer, please explain to us where it is that you differ from that figure? When you give us a figure, would you let us know what the basis for your differences are from the $608 million.

I think we previously asked Dr. Gronvall to provide for the record the basis for computing the $608 million, and I am sure he will be providing that to you and your advisors as well.

[Subsequently, the Veterans' Administration furnished the following information:]

After a close review of the situation and considering recent congressional action on the VA 1989 appropriation bill, we estimate the projected shortfall to be $432 million.

One cause of this shortfall is the enactment of Public Law 100-322 "The Veterans' Benefits and Service Act of 1988", just the mandatory cost to the VA is $106 million over what was appropriated for fiscal year 1989.

Further Federal Employee Health benefit cost increase of 26 percent will require another $61 million.

The additional costs of the Federal Civilian Pay increase from 2 percent to 4.1 percent will cost $86 million. Congress has given VA the authority to request this funding in a supplemental appropriation.

Special pay rates for nurses and other scarce medical specialties and within grade increase paid in accordance with regulations and law to all eligible employees who perform at acceptable levels will cost an additional $75 and $59 million respectively. The budget anticipated absorbing the $59 million within grade cost through filling of vacancies at lower grades. This cannot be achieved as the average GS grade in Medical Care is only 6.5. This average is significantly below the Government-wide average grade of 8.5.

Unbudgeted costs for AIDS and universal precautions are expected to increase requirements by $45 million. The universal precautions proposal for $25.8 million was not included in the $608 million figure originally discussed by Dr. Gronvall.

In summary, the minimum requirement to cover this shortfall is $423 million. DM&S medical centers have exhausted all means to absorb these costs through reprogramming.

This amount is $202.3 million below that the Chief Medical Director (CMD) testified to in the following areas:

The restoration of the productivity shortfall of $98.4 million unnecessary due to congressional action which established the Medical care employment level of 194,720. The restoration of the productivity shortfall of $98 million is unnecessary, because the shortfall was restored in the congressional add on of $215 million.

Contract hospitalization of $47.2 million is not required due to the implementation of new pricing regulations that are the same as for Medicare. These new regulations are expected to be in place January 1, 1989.

Special pay $22 million less than the additional $97.2 million. The allowance of $75 million provides for coverage of 1989 requirement of $55.2 million and partial recovery of last year absorption of the unfunded special pay requirements.

The Homeless Programs funding request $23.6 million has been offset within existing funding.

The VA has undertaken automation of the hospital system with the DHCP program and CALM improvements. The savings attributed to these type of improvements of $11 million is still valid.

Dr. GRONVALL. Your comment presumes that the Administrator will differ from it. I wanted to add: If the Administrator's judgment differs.

Mr. STEINBERG. I apologize for that presumption, and I very much hope that you and he will reach agreement on a figure. Mr. Administrator, in regard to tables 1 and 2 of your testimony, as to both outpatient and inpatient care, there are two tables attached to your testimony.

The table does not reflect the number of service-connected veterans requesting care for service-connected disabilities. Also, with respect to outpatient care, the table doesn't reflect a category for those veterans whose incomes fall within the aid and attendance income new entitlement limit that was just enacted in Public Law 100-322.

Is there a specific reason why those items are not separately listed on the table, since they are separate statutory eligibility criteria? And could those items be included on the tables in the future when they are submitted?

It would be very helpful to us, in other words, in order to track the new statutory criteria if the information we were getting would comply with the statutory criteria.

Dr. GRONVALL. Mr. Steinberg, I believe I can answer that. Those other categories are lumped on line 21 under heading "Other Non-service-Connected Category A." As you can see, there is a sizable number of veteran applicants who are category A who fall into that category.

I think for the purpose of trying to get this report, which we receive and also supply to you on a regular basis, trying to keep the report manageable and keep it on one page, we tried not to subdivide it out——

Mr. STEINBERG. Those are just two categories. We have been asking for them for a long, long time. It seems to me they are very pertinent, and we all should want to know when a veteran is being treated for a service-connected condition; and that is all we are asking for. Could we know that in both the inpatient and outpatient areas?

And with respect to the outpatient area, now we have a new entitlement in Public Law 100-322. It is not all category A veterans, as you know. It is only those with incomes of up to approximately $10,000; and we are asking if that category could be broken out separately for us.

Dr. GRONVALL. We appreciate your question. Let us take a look at it and see how we can find some way to be sure that it is put in there.

[Subsequently, the Veterans' Administration furnished the following information:]

Although it would be beneficial to collect information concerning the number of service-connected veterans requesting care for their service-connected conditions, and the information concerning the number of veterans whose income fall within the Aid and Attendance income levels, at this time we do not have the staffing and resources to collect and maintain the data. It is estimated that obtaining and tracking this information would require approximately 20 minutes per patient annually. During fiscal year 1988, there were 752,905 applications for care by veterans who are less than 50 percent service-connected and 1,112,662 by veterans who have a low income, as classified by the category "A" criteria. this data collection and maintenance would become a continuous program and would require an additional 299 FTEE with an annual salary cost of $5,274,000. The tracking of the number of service-connected veterans requesting care for their service-connected conditions would be a burden on the administrative and clinical staffs and would take a significant amount of time to computerize and the quality of the data would be questionable.

Mr. STEINBERG. I would think, Mr. Administrator, it would be helpful to you in looking at those tables, just as it would be helpful to us if we could have those figures.

Mr. TURNAGE. It may be gratuitous, but I think it is also probably constructive to say that one of the respondents this morning talked about the complexity of definition of eligibility for different kinds of services. And if you recall, in the overall inpatient care, we make that quite a clear thing: categories A, B, and C.

We have further complicated it when we talk about Public Law 100-322 now because it is not A, B, and C per se; when we are talking about over 50 percent disabled, 30 or 40 percent disabled, 10 percent disabled, and so forth.

Mr. STEINBERG. I will be glad to discuss privately with you how that happened.

Mr. TURNAGE. Maybe we can discuss how to resolve it later. [Laughter.]

Mr. STEINBERG. Fine. With respect to the 15 charts attached, could we receive such charts on a quarterly basis? Would that be a possibility, or would that be a difficult thing to do—updated charts quarterly?

Mr. TURNAGE. As a matter of fact, I am rather surprised that you asked the question because I thought you probably were receiving them. We publish them monthly in most cases having to do with means test data, as you know, and then quarterly other data that provides management tools both to Dr. Gronvall and to me as to how best to administer the program.

Mr. STEINBERG. I was talking about the 15 charts.

Mr. TURNAGE. To answer your question, we would be delighted to do that.

Mr. STEINBERG. All right. The 15 charts as distinguished from the two tables; we get the tables now monthly, but we would like to have the charts regularly if we could. And if they are available monthly, we would like to have them; but we wouldn't want anything done especially for us.

Mr. TURNAGE. Please let me make an inquiry here first.

Mr. STEINBERG. Of course. Let me now yield to the Minority General Counsel, Tom Roberts.

Mr. ROBERTS. Thank you, Jon. Dr. Gronvall, I am going to ask you a question about the $608 million figure. Is the $608 million figure that we have been talking about—the shortfall—based on the assumption that the VA would implement all its discretionary authorities? Do you know?

Dr. GRONVALL. You would have to be clearer to me on discretionary authority as to what you mean by "implement its discretionary authority."

Mr. ROBERTS. In the medical-care field, programs other than entitlement programs.

Dr. GRONVALL. No, sir. This projection of a shortfall is based on the present pattern of medical care. It makes no assumption about changing, restricting, or restraining by policy, care to category C veterans or category B veterans or various categories that have just been described on outpatients, where there is discretion to the Agency.

So, this is a projection forward of essentially the present operation, adding to it new mandates in the current appropriation and projecting that into the next year. The purpose of the elaborate review that we have been going through now for several months is to come up with a set of such actions that we can take where the VA has the discretion, to ensure that, as we start the next year, we match our program commitments to our budget.

Mr. ROBERTS. Thank you.

Dr. GRONVALL. I appreciate that clarification.

Mr. ROBERTS. Some medical centers have argued—and I will direct this both to the Administrator and Dr. Gronvall—that the VA has not kept pace with the medical Consumer Price Index, the medical CPI. I would like to know your thoughts on that and, in connection with that, whether you believe the VA, because of its size and purchasing power, really needs to keep up with the medical CPI; or maybe, stated another way, is the medical CPI relevant to the Veterans' Administration medical system?

Mr. TURNAGE. I will make a couple of comments, and then I will ask Dr. Gronvall to embellish it, please. I don't think they are entirely applicable because of a number of differences that we enjoy that are not enjoyed by the private sector, for example, simply in the matter of procurement.

We now have engineered some new systems which have been highly lauded by people who have been involved and are privy to it where we expect, for example, this year to save over $5 million in procurement and, in the next 5 years, save something like $75 million, simply because of the methods of procurement—computerization of it—and modernization of the system.

So, there are other similar type things that we are privileged to have. For example, in the last half dozen years, we have approached almost a half billion dollars that have been spent in computerization of the system within each of the hospitals, which adds to productivity otherwise.

I am not sure that the private sector has similar kinds of endeavors going on and how they measure it; but having said that, I would like to let Dr. Gronvall go with the rest of it, please.

Dr. GRONVALL. I would agree with what the Administrator said. We do get some very significant savings through very large purchases that we are able to make.

Your question was: Have we kept up? And I think "kept up" is a comparative term. For my answer, I would relate the VA again back to the private sector of medicine. The purpose of my introductory remark was to portray my judgment that over a decade the total funding available and utilized in the private sector has grown in real terms some 20 percent, while in the VA it has been level.

When there are discussions or questions about the standard of quality of care, it is clear that that standard is set in the private sector of medicine in this country by and large. The benchmark against which we are always compared is the best of medical care in the community hospitals and in the university hospitals.

I believe that much of the pain that has been portrayed by our medical center people here today comes about on that kind of comparative basis, that when the pace of replacement of equipment in the VA, the pace with which we can acquire new technology are compared to what is going on in the best of private medicine, that gap between the true funding increase in the private sector and the level support system in the VA is reflected in a lower pace of such equipment purchases in the VA.

It is on that basis, I think, that much of the comparative kinds of comments were made here today, that there is an accumulating, built-in problem of significant dimension in the Veterans' Administration.

Chairman CRANSTON. I apologize for my absence, and I am glad to be back. On page 3 of your testimony, Tom, you state that you are convinced that "all veterans who are entitled to VA health care" will be able to receive it in both fiscal years 1988 and 1989.

Am I correct in assuming that you mean all category A veterans who require inpatient care and all those veterans provided an entitlement for outpatient care in section 101 of Public Law 100-322?

Mr. TURNAGE. Yes, sir. And Mr. Chairman, not to hit on a technicality, but to be sure our answer is in the vein that I think you asked the question. The entitlement becomes the question. Category A are included as "shall have care" and others are "may."

So, within that context, yes, sir. I think my statement is entirely consistent.

Chairman CRANSTON. How much money do you estimate the Agency will save in fiscal year 1989 by limiting care to those so-called "entitled categories"?

Mr. TURNAGE. I can't tell you, sir, except that I can tell you precisely for the record because our data is very definitive. We know the percentages of the people in both B and C who have been treated, and it is a matter of just computing it and getting the information to you.

[Subsequently, the Veterans' Administration furnished the following information:]

The Agency will re-direct an estimated $30 million in fiscal year 1989 to meet operating shortfalls by reducing the number of veterans in discretionary workload categories that the VA will treat. By reducing the amount of care rendered to veterans in the discretionary categories, we will be able to continue delivering high quality care to veterans whom Congress has directed VA to provide care.

Our overall strategy designed to produce the $30 million reduces, but does not eliminate, the discretionary patient workload. Our action plan calls for a reduction in the proportion of discretionary patient workload in the entire system to the level in our Departmental region having the lowest proportion. The impact of this policy will vary throughout the system, because the proportion of mandatory to discretionary workload spans a considerable range. Each region will be required to develop a workload plan which will project the number of mandated and discretionary patients to be treated. As the year progresses, funds will be shifted, as necessary, from facilities treating more than their share of discretionary patients to facilities which, because of the volume of mandatory patients and other such factors, find themselves short of funds required to treat the number of discretionary patients in the original, regional plan.

While reducing discretionary patients is the keystone of our plan, we intend to reduce costs in several other ways as well, for example, by decentralizing to the VA Medical Centers the management of certain non-VA workload accounts, by restricting prescriptions written by fee-basis physicians to drugs in the VA formulary, and by restricting organ transplant services to care-mandated veterans in VA facilities or facilities with which we have sharing agreements.

Chairman CRANSTON. Do you intend not to provide care to those in the "may" categories?

Mr. TURNAGE. We have no such intentions at the present time. As a matter of fact, we are trying to evaluate where we stand and what will happen in the supplemental, if that occurs, and what we can project; and within that kind of framework, make the decision.

Chairman CRANSTON. At the committee's March budget hearing in response to a question asked by Senator Matsunaga, you indicated that you were reviewing the recommendation of the Hawaii task force for us to build a hospital there.

When do you expect to be making a decision on that recommendation?

Mr. TURNAGE. We did make the statement at the time, and we did have a task force report from there. We have looked at it; we have evaluated it, and we are looking at other alternatives which may be feasible as opposed to that particular option, although that option has not been entirely ruled out, sir.

Chairman CRANSTON. Senator Matsunaga also wanted me to ask you what specific concerns you have about that recommendation.

Mr. TURNAGE. I think one of the issues concerned with it—and maybe Dr. Gronvall, who also has been in on these deliberations from the very start—is the cost effectiveness of that alternative as opposed to the number of people who would require treatment there.

For example, Tripler is one of the alternatives, a wing at Tripler being refurbished exclusively for the VA system; yet even if we kept Tripler as a wing essentially for some surgical patients and some psychiatric patients, still maintaining the outpatient clinic in downtown Honolulu. So, I think that dollars become an issue here and whether or not the demographics require the building of a hospital.

As I recall—and I think I am close—the proposal by the task force was a hospital of only 100 capacity in any event. Was that close, John?

So, there may be some other more cost-effective means of providing the same quality care.

Chairman Cranston. On page 7 of Dr. Gronvall's testimony, he states:

> It is the policy of the VA to operate and maintain a sufficient number of beds to meet the needs of veterans applying for admission and found to be in need of hospital care or medical services.

You state on page 3 of your testimony:

> All veterans who are entitled to VA health care will be able to receive it in both fiscal years 1988 and 1989.

These two statements seem to contradict each other. Am I correct in that? And would you please indicate which actually states the Agency's position?

Dr. Gronvall. I am having trouble, I think, seeing an inconsistency. The Administrator's statement indicates that all entitled veterans will be able to be cared for. The statement of the Chief Medical Director describes a kind of operating practice or procedure that each year, on the basis of the funding we have and the number of veterans applying to us for care and the number of veterans we can care for on that basis, that is the number of beds we attempt to operate.

And I believe those statements are not inconsistent.

Chairman Cranston. The PVA, on page 2 of its testimony, quotes you, Tom, as stating in your remarks to their annual convention on August 24, that:

> This administration has done more to improve and enhance veterans' benefits and services than any administration since the Second World War.

I would like to ask how you square that type of statement with the administration's fiscal year 1987 budget proposal to cut VA medical-care staffing by nearly 9,000 FTEE, inpatient episodes of care by 60,000, and outpatient visits by 1.1 million, and your fiscal years 1988 and 1989 budget proposals to cut medical-care staff by 3,800 and nearly 1,800, respectively.

Mr. Turnage. First of all, I am looking at the overall picture from the start of the administration until the current date, sir, based on the dollars that have been put into the system, the constructive achievements that have been made in the meantime, the enhancement of the infrastructure of the system, the entitlements that have come not only in health care but in compensation and pension and the COLA implications, and all the other facets of, in effect, the VA's philosophy and requirement to administer these programs.

Now, let me suggest something else. That could not have been achieved and was not meant to preclude the consideration that it could not have been done without the support of the Congress and this body and the body in the House, as well as the Appropriations Committee.

And I pointed out in my speech also—and I know it almost verbatim because it is parochial in this sense—that we can't proceed with having adequate benefits in this country for veterans without having three entities involved. One, the administration—and I say the incumbent administration—I say the Congress; I say support of the people of the Nation.

And it is important from my perspective then that we give the right perspective to the Nation with regard to the activities of the VA. And when I hear disparaging remarks about it and about the disastrous budgets and about the quality of care and the fact that the system is being dismantled and the fact that we are insensitive to the concerns of the veterans, I don't think that does the veteran any good; I don't think it does the VA any good, and I don't think it does the Nation any good.

Chairman **Cranston**. It wasn't exactly a collaboration that led to the additional funding that you received. As a matter of fact, Congress increased the administration's request for VA medical care by over $500 million in 1987; for fiscal year 1988, by over $240 million; for fiscal year 1989, by $215 million.

Over the last 8 fiscal years, a total of $1.6 billion was added over the opposition of the administration. If Congress had not been doing this on a bipartisan basis for the most part, you wouldn't have the support that you have had to the degree that you have had it for medical care.

What would have been the effect on the VA, on the health-care system, if Congress had simply enacted the budget requests that came from this administration in each of those years?

Mr. **Turnage**. I am not sure there would have been some of the horrendous implications that might be suggested. For example, we are not as concerned—and we have talked about it here this morning—with regard to management initiatives and management flexibility, about floors and ceilings and constraints and otherwise.

I don't think, Mr. Chairman, it is always numbers that are important; I think it is how you use the system that is available to you. And if we, for example, had dollars but didn't have some of the other constraints, I think we would still be able to provide the same quality, if maybe not more quality care.

Chairman **Cranston**. I wonder how the heads of the various hospitals who were on that panel a while ago would have gotten along with $1.6 billion less over the last 8 years. The problems that they cited today would have been far more severe had we not gotten them that help.

Mr. **Turnage**. Let me suggest one thing in response. Mr. Chairman, as the VA Administrator administering this program, I must tell you that I am grateful for your efforts and the whole committee for whatever we get in here, as opposed to what is asked for; and it is more, that is great.

The fact is, though, that you understand the system far better than I. You have such a sophisticated understanding of it, and you understand the process; and you also know the competing elements in this country right now for dollars that are available.

I don't think—and I keep saying this also in my speeches—that we will ever get all we want. I am after all we need to do our job well.

Chairman CRANSTON. I thank you for that. We are up here, obviously, out to get all that we legitimately and properly and appropriately can to see that you have the tools to do what you need to do.

The National Organization of Nurses states, on page 7 of their testimony, that:

> At one VA hospital in the South, nurses were frustrated by the refusal of prosthetics to supply wheelchair cushions for patients on the long-term care unit. The nurses obtained a $25 donation, went to a local upholstery store and purchased a large foam mattress and, with an electric knife borrowed from the mother of one of the nurses, cut the foam to make wheelchair cushions for her patients.

I presume that is not the way you want basic medical care for veterans provided.

Dr. GRONVALL. Absolutely not.

Chairman CRANSTON. Dr. Gronvall, over a year ago, you told me you were looking into the VA developing a specific DRG for AIDS. Where does that effort stand?

Dr. GRONVALL. Our effort, I am unhappy to tell you, came to a frustrating end. We had a task force of people, including the individuals from our specific medical centers who are most immediately involved in AIDS; our task force was led by Mr. Garfunkel, who is the director of our Manhattan hospital.

The complexity of documenting all of the costs of either an individual AIDS case—and they are not uniform by any means—and the complexity of all of the other associated AIDS costs in the hospitals really led to a conclusion coming out of the task force that we could not simply adopt a DRG for AIDS.

Interestingly, at about the same time, I think the Department of Health and Human Services came to the same conclusion in regard to Medicare funding. We have continued the work, and Mr. Garfunkel's task force has continued to work to try to give us a more comprehensive mechanism by which we can keep track of the AIDS cases in each hospital and make appropriate adjustments in our budget allocations to the hospitals with a large AIDS experience.

We will not be doing that through a specific DRG but through a combination of other factors. We made additional allocations during this past year for AIDS. Our 1989 appropriation takes specific recognition by adding funds and staff for the 16 hospitals that have the greatest extent of AIDS experience; and we will be allocating those specific incremental funds, of course, to those 16 hospitals.

Chairman CRANSTON. Does the VA intend to continue its policy of supplementing the funding for VA facilities that treat the largest number of AIDS patients?

Dr. GRONVALL. Yes, but that is a commitment that is within the context of all of the budget priorities of the department; but clearly, AIDS continues to be a growing problem. Both the numbers and the costs continue to go up. So, we will actively seek ways to deal with that in supporting the hospitals with the greatest number of AIDS patients.

Chairman CRANSTON. Money was added for that purpose in the immediate past. What about in 1989?

Dr. GRONVALL. What I just referred to was a specific increment in the 1989 appropriation, identified for the 16 hospitals with the greatest AIDS experience; and that money will be, of course, allocated to those hospitals.

Chairman CRANSTON. Do these supplements adequately cover the cost of caring for AIDS patients at all of these facilities?

Dr. GRONVALL. Adequately is a judgment, but I think the answer is that the allocations we have been able to make do not fully cover the total cost of all of the problems associated with AIDS. No, sir.

Chairman CRANSTON. Would you please, John, describe when you first became concerned about a serious budget shortfall for fiscal year 1988 and fiscal year 1989, and the various steps you undertook to try to determine the extent of the problem, and how you would deal with it?

If you would begin with your knowledge on February 1 when the budget was submitted and move forward to the appointment of your task force?

Dr. GRONVALL. To do justice to that would be an answer longer than anyone would want to hear, I guess.

Chairman CRANSTON. Suppose you do it in writing then?

Dr. GRONVALL. All right. I can easily hit in 2 or 3 minutes the highlights of it, if you want me to do that.

Chairman CRANSTON. Maybe you had better do it in writing.

Dr. GRONVALL. I will be pleased to.

[Subsequently, the Veterans' Administration furnished the following information:]

FISCAL YEAR 1988 AND FISCAL YEAR 1989 MEDICAL CARE BUDGET CHRONOLOGY

Date	Event
June 30, 1987	House passed H.R. 2616.
Oct. 1 to Nov. 10, 1987	1st continuing resolution (CR).
Nov. 11 to Dec. 16, 1987	2d CR.
Nov. 1987	Bipartisan agreement on 1988 levels.
Dec. 4, 1987	Senate passed H.R. 2616 (Senate version).
Dec. 17 to 18, 1987	3rd CR.
Dec. 19 to 21, 1987	4th CR.
Dec. 22, 1987	Public Law 100-202, fiscal year 1988 appropriation ($10,094,808,000).
Jan. 6, 1988	OMB passback on 1989 budget.
Jan. 19, 1988	Apportionment approved by OMB.
Jan. 26, 1988	TDA issued by Controller.
Feb. 2, 1988	10A2 memo to 10B recommended $58,000,000 withdrawal.
Feb. 18, 1988	Release of President's 1989 budget.
Mar. 2, 1988	HVAC hearing on 1989 budget
Do	$10,000,000 special AIDS allocation made to field.
Mar. 4, 1988	SVAC hearing on 1989 budget.
Mar. 7, 1988	RD's recommend against $58,000,000 withdrawal.
Mar. 8 to 10, 1988	House Appropriations Committee hearing on 1989 budget.
Mar. 14, 1988	Senate Appropriations Committee hearing on 1989 budget.
Mar. 16, 1988	HVAC hearing on construction 1989 budget.
Mar. 25, 1988	Hotline discussion on budget difficulties.

FISCAL YEAR 1988 AND FISCAL YEAR 1989 MEDICAL CARE BUDGET CHRONOLOGY—Continued

Date	Event
Mar. 29, 1988	House passed an amended version of H.R. 2616.
Mar. 30, 1988	Paul Thomson calls on $58,000,000 reduction.
Apr. 21, 1988	Conference agreement—H.R. 2616.
Apr. 27, 1988	House agreed to conference report—H.R. 2616.
Apr. 28, 1988	Senate agreed to conference report—H.R. 2616.
Apr. 29, 1988	CMD approves $25,000,000 withdrawal from field.
Apr. 30, 1988	$25 million withdrawn.
May 4, 1988	HVAC hearing on legislative items.
May 5, 1988	CMD memo to Administrator requesting supplemental for H.R. 2616.
May 9, 1988	Administrator's letter to OMB re H.R. 2616, recommends Presidential approval and States need for emergency supplemental (1988) and a 1989 amendment.
May 20, 1988	Public Law 100-322 signed.
May 25, 1988	1988 supplemental for Public Law 100-322 transmitted to OMB.
June 22, 1988	House passed 1989 appropriation.
June 27, 1988	State home per diem increase sent to field.
July 6, 1988	CMD letter to congressional committee reimplementation of Public Law 100-322 by internal reprogramming.
July 6 to 7, 1988	FAC meeting of 1989 budget strategy.
July 11, 1988	Denver regional budget meeting.
July 13, 1988	Senate passed 1989 appropriation.
July 13, 1988	Hartford regional budget meeting.
July 19, 1988	Chicago regional budget meeting.
July 19 to 27, 1988	Beneficiary travel sent to hospitals ($9,700,000).
Aug. 2, 1988	Both Houses passed conference report on 1989 appropriation.
Aug. 4, 1988	Senate passed 1988 supplemental for Public Law 100-322.
Aug. 4, 1988	Final report, CMD's task force on 1989 budget.
Aug. 11, 1988	House and Senate passage of 1988 supplemental conference report.
Aug. 14, 1988	1988 supplemental appropriation, Public Law 100-393 ($31,700,000).
Aug. 19, 1988	Public Law 100-404, 1989 appropriation ($10,542,546,000).
Aug. 23, 1988	Outpatient and Saturday premium pay ($10,900,000) sent to field.
Sept. 1, 1988	1989 supplemental and 1990 budget requested of OMB.
Sept. 6, 1988	AIDS supplemental sent to field ($364,700).
Sept. 7, 1988	House hearing on 1988 and 1989 fiscal situation.
Sept. 9 (Sept. 20)	Senate hearing on 1989 fiscal situation.

Chairman CRANSTON. On page 8, John, of your testimony, you state that the current VA occupancy rate is 73 percent and that a more efficient and cost-effective level of 85 percent could be achieved by reducing the level of operating beds while maintaining the level of patients treated. Does this mean that the VA plans to close about 15 percent of its beds? Or are these the ones that are out of operation according to the House committee survey?

Dr. GRONVALL. I don't think I can answer that with an "either/or." The fact is that, if we had an 85 percent occupancy rate, given the present patient census, we would need to be operating fewer beds than we are now operating. That is the reason why earlier, when you were out of the room, I responded that getting additional beds reopened was not on a short priority list of what we wanted to do in 1989.

When we project ahead in terms of planning—new facilities, renovations, et cetera—we use 85 percent because that is a more desirable occupancy standard. So, we use that in a planning sense. The bed issue, of course, is complicated by legislation that mandates that a certain number of beds be available; and then there are other factors that impact on that.

Chairman Cranston. When you calculated the occupancy rate and arrived at the figure of 73 percent, were you including the 13,000 beds identified by the House committee?

Dr. Gronvall. I think I would need help on the answer to that question. I believe it is a calculation from the official operating bed count, which does not take into account the beds closed; but I would need help on that.

Dr. Winship is here, and maybe he can answer that.

Dr. Winship. Mr. Chairman, I believe that 73 percent occupancy is based not on the 90,000 nor on the approximately 75,000 or 76,000, but rather on a figure that we have developed over the last few years of our official operating bed level, which is approximately 85,000.

So, it is that 85,000 which we use then as the target for the calculation of the occupancy rate.

Chairman Cranston. Thank you. It would appear, John, that if you close 15 percent of the beds, there would be very few beds available for the contingency purposes which you cited as part of your mission. Is that correct?

Dr. Gronvall. We have a specific commitment to be able to provide, in certain periods of time, after declaration of a national emergency, a certain number of staff beds for contingency purposes. As we have reviewed our operation, we continue to be internally assured that, if a national disaster were declared, we could meet that commitment.

Chairman Cranston. You provided us a voluminous DM&S report which itemizes equipment, which has exceeded prescribed equipment life expectancy but which is still in service. Do you have the total replacement costs for items which have exceeded the standard in fiscal year 1988 and previous years and have not been replaced—that is, the backlog? And the total replacement costs for items which will exceed their prescribed life expectancy in fiscal year 1989?

Dr. Gronvall. We would have to supply that for the record, but we have that information, of course.

Chairman Cranston. All right. I would appreciate it if you would supply that for the record.

[Subsequently, the Veterans' Administration furnished the following information:]

Total replacement equipment requirements for 1988, including previous years' are estimated to be $478.8 million. The budgeted level for this requirement is $98.5 million leaving an end-of-year backlog of $380.3 million in 1988. This 1988 backlog of $380.3 million plus a projected requirement of $263.1 million in 1989 results in a total requirement of $643.4 million for 1989. The budgeted funding level for 1989 is $113 million leaving a projected end-of-year backlog of $530.4 in 1989.

These replacement equipment requirements were obtained from the annual update of the VA's LOG I Report No. 085 dated 12/31/87. The following chart recaps the replacement equipment requirements and backlog.

[Dollars in thousands]

	1988	1989
Prior years (carry over)	289,026	380,265
Current year requirements	189,777	263,086

[Dollars in thousands]

	1988	1989
Total required	478,803	643,351
Amount budgeted	98,538	112,967
End-of-year backlog	380,265	530,384

Chairman **Cranston**. We will have a good many written questions, and other Senators will have some to add to those that I will have.

I think that completes our work with you today. I thank you very much for your patience and for your testimony.

Mr. Turnage. Thank you, sir.

Dr. **Gronvall**. Thank you, sir.

Chairman **Cranston**. I would now like to welcome a panel of VA regional directors. Would you please come forward? Mr. Robert Lindsey, Regional Director, Department of Medicine and Surgery, Veterans' Administration, region 6; Mr. Donald Thompson, Regional Director, Department of Medicine and Surgery, Veterans' Administration, region 3; Mr. Albert Washko, Regional Director, Department of Medicine and Surgery, Veterans' Administration, region 1; and Mr. Albert Zamberlan, Regional Director, Department of Medicine and Surgery, Veterans' Administration, region 4.

Would you all please rise so that I can administer the oath, as we have done with the previous panels?

[Whereupon, the witnesses were duly sworn.]

Chairman **Cranston**. Mr. Lindsey, would you please begin?

STATEMENT OF ROBERT E. LINDSEY, JR., REGIONAL DIRECTOR, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION, REGION 6

Mr. **Lindsey**. My name is Robert E. Lindsey, Jr. I am the Regional Director of the western region, a region which encompasses the States of Alaska, California, Idaho, Washington, Oregon, Nevada, Hawaii, and our facilities in the Philippines and the Pacific Basin.

The three most pressing problems that I see facing the western region, in addition to the budget shortfalls in fiscal year 1989, are a cumulative backlog of some $75 million which the western region will be carrying over into fiscal year 1989; the necessary diversion of millions of dollars worth of equipment in fiscal year 1988, on top of a very significant backlog of equipment needs which we have not been able to replace, in spite of a spirited defense by the department in support of reducing our equipment backlogs which need to be accomplished very, very quickly.

And finally, the third problem that I see is that there are several medical centers within the Western region that will be in violation of the Antideficiency Act this year, and we as a region are helping to find the resources to support and overcome their deficit at this time to preclude their being in violation of that act.

I know that the department has made a spirited defense to reduce those backlogs over the past couple of years and has not been successful; and now, on top of that, we have had to divert millions of dollars in the Western region to support workload and FTEE, which further compounds that problem.

Chairman **Cranston**. Thank you. Mr. Thompson?

STATEMENT OF DONALD THOMPSON, REGIONAL DIRECTOR, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION, REGION 3

Mr. **Thompson**. I represent the southeastern region, which is comprised of the States of Kentucky, Tennessee, Mississippi, Alabama, Georgia, South Carolina, and Florida. We have 21 medical facilities, and we have 12 outpatient clinics, with one other clinic currently under construction.

I have been in the Veterans' Administration now for 29 years, and I have served in nine hospitals and served in four different capacities in the VA Central Office, the last prior to my current job being the Executive Assistant to Dr. Donald L. Custis, who was at that time Chief Medical Director. I have been Regional Director now for 7 years.

The greatest problems that we face in my region are the rapidly expanding workloads, particularly in Florida, Georgia, and the coastal areas; the shortages in our recurring dollars, as mentioned, very similar to Mr. Lindsey's region; and the mal-distribution of our facilities and our resources within our region.

Chairman **Cranston**. Thank you very much. Mr. Washko and Mr. Zamberlan, I am sorry to say that I have to depart at this point; but the staff will carry on. We appreciate very much your presence and that of all others who have been with us today, whether actively or observing and operating on this matter in one way or another.

Thank you all very much. Please carry on.

Mr. **Steinberg**. Were you finished, Mr. Thompson?

Mr. **Thompson**. Yes.

Mr. **Steinberg**. Mr. Washko, would you proceed, please?

STATEMENT OF ALBERT WASHKO, REGIONAL DIRECTOR, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION, REGION 1

Mr. **Washko**. My name is Al Washko. I have been with the VA for 20 years. I have been the Regional Director of the northeast region for 3 years. Prior to that, I was a Hospital Director in Albany; prior to that I was an Associate Director at two different facilities; and prior to that, I did a tour as a staffer in the Central Office.

The States that comprise the northeast region are Maine, New Hampshire, Vermont, New York, Connecticut, and Rhode Island. I also have responsibility for Puerto Rico. That encompasses 24 VA medical centers.

The three problems that I see confronting the northeast region are as follows: The first has to do with dollars, operating dollars and equipment dollars. I think that has been adequately testified to today by the various panels, and I will stand on their testimony for that.

The Federal pay scale is the second problem that is of major concern in the northeast. The northeast has two of the highest cost areas in the country—Boston and New York—and we face major, major difficulties in recruiting quality staff because of the Federal pay scales. As a result of that, we are one of the regions that applies for the most special pay; but the special pay mechanism, while it is very helpful and while we appreciate that mechanism being available, is not satisfactory.

The Federal Executive Board in New York City has recently petitioned the Office of Personnel Management for a differential; I believe it is 20 to 25 percent, but don't hold me to that figure. But we are having difficulties in virtually every category in the Boston area and in the New York area.

The third problem I would cite would be construction; 12 of the 24 VA medical centers in the northeast have been virtually unrenovated with major renovation since they were opened. The average age of these unrenovated facilities is 40 years. So, essentially, half of my medical centers are 40 years old without major improvements having been put into them.

This has a major effect on recruitment because quality staff wants to work in quality physical plants with quality equipment.

So, those would be the three problems that I would cite.

Mr. STEINBERG. Thank you. Mr. Zamberlan?

STATEMENT OF ALBERT ZAMBERLAN, REGIONAL DIRECTOR, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION, REGION 4

Mr. ZAMBERLAN. My name is Al Zamberlan. I am the Regional Director for the Great Lakes region. My region geographically comprises five States—the States of Ohio, Indiana, Illinois, Wisconsin, and Michigan. There are 21 medical centers in those five States; 20 of those are hospitals, and one is an independent clinic.

Prior to my assuming the role as Regional Director—and I have been the Regional Director since July of 1981—I served as the Director in three VA medical centers—Ann Arbor, Allen Park, and Clarksburg; and prior to that, I served as an Associate Director in Ann Arbor and the Bronx. I have served in Washington on one of my assignments for 4 years.

The three principal problems that we are experiencing in the Great Lakes region are very similar to what my colleagues have just mentioned to you; but the most significant is the funding shortfalls, the shortfalls that have accumulated over the last 3 years because of some of the absorptions, specifically the 1 percent productivity absorptions.

The other is our inability to use equipment money for the intended purposes. Our replacement equipment is really deteriorated; our ability to actually keep pace with high tech is really a concern of ours because of our inability to retain competent physicians and staff and also to recruit.

Then, finally, my concern about the quality of our M&R work that we are actually experiencing in our medical centers because they have to divert those dollars to maintain a certain level of employment.

Those are my three specifics.

Mr. **Steinberg**. Fine. Thank you very much. I would now like to ask you the same question that Senator Cranston asked of the field witnesses. That is, did you bring with you the written responses to the questions that he submitted to you in writing? If each of you has them with you, would you please give them to the staff at this time and indicate whether or not you understand that, in providing that information, you are providing it pursuant to the committee's request and that you appreciate that you are under oath in providing that information to the committee?

If anyone dissents from that appreciation, please let us know.

[No response.]

Mr. **Steinberg**. All right. Thank you all very much for undertaking that data gathering. We know that it was a substantial task.

Could each of you say whether or not in your experience in the system—and give the total number of years that you have been in the system in each case before you answer—is this the worst crunch you have seen for the VA health-care system? We will start with Mr. Zamberlan.

Mr. **Zamberlan**. I have been in the VA system my entire professional career, which is 27 years on health care; and I like Dr. Newcomb's definition of concern. A lot of people have used the word "crisis."

Mr. **Steinberg**. I used the word "crunch."

Mr. **Zamberlan**. All right.

Mr. **Steinberg**. I tried to stay away from the medical term.

Mr. **Zamberlan**. I think we are really at a turning point. I think Dr. Gronvall has said it very specifically—that we have run out of flexibility. And I think to go on and try to continue what we are doing, we do not have the flexibility that we have used in the past to literally try to maintain the levels of employment that we have and to maintain the workload that we have.

I mean, I think we have reached that; so this has been the most challenging time in my career, in the 27 years that I have actually been in the Veterans' Administration.

Mr. **Steinberg**. I think Dr. Musser earlier testified that we have squeezed the last drop of water out of the system; I think those were his words. I will let you answer the question that way, and I will repeat the question for Mr. Washko, as we move down the panel.

Is this the worst funding crunch that you have seen in your years in the system, and how many years has that been?

Mr. **Washko**. I have been in the system for 20 years, and this is the most difficult period that I have witnessed.

Mr. **Steinberg**. And the most challenging, therefore?

Mr. **Washko**. And the most challenging. Never before have I seen joint replacements being delayed, as Dr. Musser indicated. In one of my facilities, joint replacements are being delayed for up until February 24. Some of these patients are category A patients; and so, this means that, for some period of months, some of our patients are enduring additional pain due to delayed surgery.

Mr. **Steinberg**. For how long are those joint replacements being delayed?

Mr. **Washko**. As of last Wednesday, they were scheduling joint replacements for February 24.

Mr. **Steinberg**. I believe that is almost 6 months.

Mr. **Washko**. Yes, that is correct.

Mr. **Steinberg**. Did you have further information on that that you wanted to provide?

Mr. **Washko**. I wanted to make one other point. Never before have I seen pharmacy and therapeutics committee deleting drugs from the formularies purely for cost reasons.

I had a Chief of Psychiatry in my office a couple of weeks ago complaining that a particular drug had been deleted from the formulary purely for cost reasons. And while he could understand that it is expensive, he was greatly distressed that he wasn't being allowed to use a new medication for the benefit of his veterans.

Mr. **Steinberg**. Mr. Thompson, we welcome you back here. You are an old friend from your days in Washington.

Mr. **Thompson**. Right. Thank you.

Mr. **Steinberg**. I am sure the air is a great deal cleaner out in the field. [Laughter.]

Mr. **Thompson**. I said earlier that I have been in the system for 29 years. Actually, I was thinking about my total Federal service. I have been in the Veterans' Administration now for 24 years; and I would say, in terms of recurring dollars, this is the worst I have ever seen it.

I must say, however, that in our region—in the southeast region—we are relatively better off today than we have been in the past when compared to the other regions because we have had some shifting of funds, and we have had some significant constructions in the last 4 years, particularly in terms of new ambulatory care facilities.

But this is the worst problem I have ever seen in terms of recurring dollar basis.

Mr. **Steinberg**. Which are the dollars that keep the system going.

Mr. **Thompson**. That is right—the operating funds.

Mr. **Steinberg**. Mr. Lindsey?

Mr. **Lindsey**. I have been in the VA for 29 years. I guess that makes me a little bit senior around the table.

Mr. **Steinberg**. Just slightly.

Mr. **Lindsey**. And I am trying to think back to when I first came with the VA and the flexibility that I had as a manager when I was a Director of Engineering Service at various medical centers, when I was a Medical Center Director at two VA medical centers, when I was the Medical District Director or Director of Operations in the Central Office, or the Director of the Engineering Service in the Central Office, and now currently this position.

I have never seen such a level of frustration in a nursing service tied to such a high level of loyalty and dedication. Without their loyalty and dedication to the veteran patients that they serve, I shudder to think what would be happening in our system right now.

I have never seen such a diversion of equipment, funds, and nonrecurring M&R funding to support recurring purposes, a shift of nonrecurring resources to support recurring resource needs, and the terrible consequences of that, because what it does is it begins to slow the engine down. You don't have the dollars to invest in areas where you can save dollars.

You can't buy that piece of equipment which is cost-containment and cost-effective and will save you dollars to use for other purposes. You are continuing to pour needed dollars into a piece of equipment or an environment which gives you no payback at all and is negative in that sense.

And I have never seen the number of times now that physicians and other professionals in the VA have come to me about their concerns for the quality of what it is we are doing; and the quality of what we do is the foundation of our life in the VA. And without that, we don't have anything; and we shouldn't have a VA.

I might just conclude by saying that the health-care system by its very nature is a dynamic system. If I had to assure for Dr. Gronvall and the Administrator a responsibility, I think that my highest responsibility to them is to assure that we are providing quality of care in a safe environment.

The subtle changes in quality are difficult to quantify, but my concern is there. In terms of a safe environment, if this trend continues that we are on, then I fear that at some point——

Mr. STEINBERG. Excuse me. The trend being of taking money away from nonrecurring costs for recurring costs?

Mr. LINDSEY. Yes. That trend to support recurring needs. Then, I would question my conscience to report to the Chief Medical Director that I could assure him that we have a safe environment for our patients, for our visitors and for our staff.

Mr. STEINBERG. Thank you each for those very conscientious answers. Mr. Zamberlan, starting with you, and then each of the others: Could you tell us what the projected funding shortfall for 1989 is in each of your regions? Just give us a dollar figure, please.

Mr. ZAMBERLAN. I sure can, and this is an aggregate from 1986 through 1988; and these are absorptions that are actually identified in the target allowance and then the diversion of funds we have talked about, and also the shortages on inventory. In region 4, that figure will be approximately $85 million.

Mr. STEINBERG. Thank you. Mr. Washko?

Mr. WASHKO. A similar figure for region 1; that is in the neighborhood of $80 million.

Mr. THOMPSON. In region 3, it is $79,776,000.

Mr. STEINBERG. Mr. Lindsey?

Mr. LINDSEY. Approximately, a rounded-off figure of $75 million.

Mr. STEINBERG. They sound remarkably similar. It would seem that if we multiplied that average by about seven, we end up at about the $600 million figure that Dr. Gronvall had suggested. So, it seems as though something is adding up correctly in the numbers.

Mr. WASHKO. I would like to comment on that, if I might?

Mr. STEINBERG. Please.

Mr. WASHKO. That figure, as Mr. Zamberlan indicated, is an accumulated field shortage of some roughly $500 or $600 million.

Mr. STEINBERG. Which is not taken into account in the $600 million. Is that correct?

Mr. **Washko**. That is correct. These are accumulated shortages that the directors and chiefs of staff mentioned this morning. It is my view that this $600 million is over and above the amount that Dr. Gronvall talked about and that Senator Cranston had in the newspaper the other day which is basically for new requirements for fiscal year 1989.

Mr. **Steinberg**. As Dr. Gronvall testified, it is for new requirements and continuing the current level of services in terms of caseloads.

Mr. **Washko**. At current levels, yes.

Mr. **Steinberg**. Right, and he is going to provide us with more backup information on that. Mr. Lindsey, could you give us—for the record if you don't have it with you today—what the shortfall that you just referred to is in each of the California facilities?

Mr. **Lindsey**. I will provide that for the record.

Mr. **Steinberg**. Thank you.

[Subsequently, the Veterans' Administration furnished the following information:]

The fiscal year 1988 budget shortfall by each facility in the Western Region includes:

	Millions
Medical district 25:	
Las Vegas	$641,721
Loma Linda	4,401,341
Long Beach	5,957,247
LA OPC	1,043,540
San Diego	5,685,082
Sepulveda	5,324,296
West LA	7,335,479
Medical district 26:	
Fresno	3,758,136
Honolulu	262,069
Livermore	2,073,821
Manila	75,553
Martinez	4,228,725
Palo Alto	5,988,637
Reno	2,546,487
San Francisco	5,141,735
Medical district 27:	
American Lake	2,100,756
Anchorage	1,212,435
Boise	2,084,407
Portland	5,661,302
Roseburg	1,554,708
Seattle	4,964,856
Spokane	1,084,054
Walla Walla	695,088
White City	444,760
Total region 6	74,266,235

Mr. **Steinberg**. Could we get that within a few days possibly?

Mr. **Lindsey**. Yes, I will provide that.

Mr. **Steinberg**. That will be very, very helpful. Thank you.

Could you tell us, generally, to what extent facilities in your region are having difficulty recruiting and retaining nurses? We will start with Mr. Lindsey this time.

Mr. **Lindsey**. With rare exception—and by that I mean with the exception of one or two locations in the western region—that experience is there for all, having difficulty in recruiting and retaining nurses.

Mr. STEINBERG. How would you characterize that difficulty with an adjective?

Mr. LINDSEY. I would generally characterize it as being moderately severe.

Mr. STEINBERG. All right. Don?

Mr. THOMPSON. Our problem isn't quite the same as it is in some of the other areas because we do have a few more rural hospitals that don't experience the nursing recruiting problems that some of the metropolitan hospitals do. However, we are at this time running about 329 vacancies region-wide in nurses alone; and it is running at a rate of about 5 percent for our total region.

Mr. STEINBERG. Bob, could you quantify yours in that respect?

Mr. LINDSEY. Yes, I can provide that for the record.

[Subsequently, the Veterans' Administration furnished the following information:]

The following is a listing by facility in the Western Region of RN vacancy rates, as of June 30, 1988:

	Vacancy (percent)
Medical district 25:	
Las Vegas	8.30
Loma Linda	10.00
Long Beach	7.40
LA OPC	
San Diego	5.01
Sepulveda	6.00
West LA	14.60
Medical district 26:	
Fresno	.01
Honolulu	
Livermore	10.00
Manila	
Martinez	4.60
Palo Alto	1.90
Reno	3.07
San Francisco	11.70
Medical district 27:	
American Lake	18.20
Anchorage	
Boise	9.80
Portland	7.30
Roseburg	3.00
Seattle	6.50
Spokane	1.00
Walla Walla	
White City	7.70
Region 6 average vacancy rate is	5.67

Mr. STEINBERG. All right, fine. Al, could you help us on the nursing problem in your region?

Mr. WASHKO. We have the most problem in the New York City and Boston areas, as I alluded to earlier. The special rates have been of some major assistance, but in the special rate methodology, there is a lag behind when the dollars arrive at the medical center and when the hospitals in the private sector have raised it. That may be 6 months or so.

So, by the time the special pay has arrived, there has been a new leap taken in the private sector.

An item that hasn't been referred to: While our total numbers of nurses may appear to be at historical levels, that doesn't take into account the very high turnover rates. Two of the hospitals in the northeast have turnover rates of nurses approaching 40 percent a year; that is a very large turnover.

Mr. STEINBERG. Which two are those?

Mr. WASHKO. Manchester and Boston.

Mr. STEINBERG. Al Zamberlan?

Mr. ZAMBERLAN. Yes. In my region, I have 11 percent vacancy in the RN positions. But the most critical thing is that it is pocketed; Detroit, Cleveland, and Chicago are the most severe, and specifically it is the intensive care type nurses. Those are the ones who are giving us more of a challenge than some of the staff nurses.

Mr. LINDSEY. I might just add that, in the bay area recently, there has been a nursing strike. I am sure you are fully aware of that.

Mr. STEINBERG. Yes, and now a settlement.

Mr. LINDSEY. That has been settled. Nurses will be receiving something like a 21 percent increase in their basic salaries over the next 34 months. That will have a rippling effect throughout the VA in the bay area; and therefore, we expect to see increased vacancy percentage and turnover, and we fluctuate on that.

We are in a very dynamic area here in terms of employment, and the ability of a bureaucracy to respond to that in a timely fashion is very, very difficult. So, we kind of ride that wave as best we can.

Mr. STEINBERG. Is it correct that you would not be able to respond to the level of increase in the bay area that has been agreed in that settlement, given the present limitations in the law on special salary rates?

Mr. LINDSEY. That is correct. However, despite that, I have asked my staff to work on moving that forward as quickly as possible, knowing what the settlement is.

Mr. STEINBERG. All right. In other words, it will have to be less than competitive because of the limit that we have on the top of the grade?

Mr. LINDSEY. That is correct.

Mr. STEINBERG. Mr. Thompson, in your opinion as the Regional Director for facilities located in the Sunbelt, do you believe that the current method of resource distribution adequately recognizes the differences in demand for care throughout the system?

Mr. THOMPSON. I think it recognizes it. I think it is having some difficulty in making the resources move at the rate that they should. And then, there are several very good reasons for that.

Number 1, my region is one of two that has been a consistent gainer under our resource allocation methodology. However, in the years that it has been in place, we have gained only something like between $9 and $10 million due to the capping and corridor mechanisms that are in place.

We have just this year, however, been granted about $6 million additional that came from the other regions by way of a data validation effort that went into the RAM process, where we actually did some equalization of access. And that is a very positive move, as far as we are concerned.

Our main problem is that, given the budgetary lag, we plan the budget this year for next year, and it works its way through the process and by the time it is distributed, 18 months has gone by;

and the workload continues to grow as people migrate into the area. It is just a matter of catchup.

Mr. **Steinberg**. As to the others, do you perceive that resources are being shifted into areas of high demand to areas of lesser demand? We can start with Mr. Zamberlan, please.

Mr. **Zamberlan**. I think we have sensed that, and perhaps Don, because he is the recipient, would like to see it happen a lot sooner. One of the concerns I had—and I guess this is the place to register it—is that I have a concern about how we determine categories A, B, and C. I am thinking now of the income levels; and we use the threshold of $15,800.

If you take that amount of money in Chicago and any place where the cost of living is much more expensive, I am not so sure that the veterans are getting a fair shake. So, that has been a contention I have had.

If we think of access parity, I think income levels and costs of living in metropolitan areas, such as California and the rest, there has to be some recognition for that; and maybe there should be some adjustment. If that were true, I don't know how much more shifting would take place.

Mr. **Steinberg**. Mr. Washko?

Mr. **Washko**. Generally, I agree on the concept that resources ought to be in the various parts of the country in proportion to the category A high priority veterans.

Mr. **Steinberg**. Is it your perception that that is happening?

Mr. **Washko**. I don't think that is happening completely. I think we need to move toward that, and there are some recommendations that we have participated in as a group that we are making to Dr. Gronvall to move that forward.

Mr. **Steinberg**. Thank you. What are your perceptions, Bob?

Mr. **Lindsey**. I agree as well that we should equalize that. I don't, however, believe at the present time that we have the systems in place to do that equitably. We can look at narrow gauges of where the dollars should be; but unless we have an entire, whole picture before we make those kinds of decisions, we will run into trouble.

For example, right now I don't believe we take due cognizance of the effect of AIDS which is rampant primarily right now on the east and west coasts and is moving inland into some of the major cities. And there are other health problems that would help to equalize that.

So, I think that the methodology that we use to do that goes beyond our current RAM structure.

Mr. **Steinberg**. All right. Did you want to say something, Don?

Mr. **Thompson**. I would just like to add one thing. In our region, because of the pressures of ever-increasing new patient workload coming in, we have for the last 3 years been making our allocations to individual medical centers on the basis of priority workloads; and it has worked rather effectively for us.

Mr. **Steinberg**. I believe that both Don Thompson and Al Zamberlan were members of the Chief Medical Director's task force that we have heard so much about this morning. Could you tell us how the estimate of $819 million was arrived at? Would either one of you or both of you like to speak to that?

Mr. **Zamberlan**. I will start. That is a figure, I think, that Dr. Gronvall mentioned earlier. That is a figure that the Central Office is looking at as the impositions based on Public Law 100-322 and several others. That is the shortfall that Al Washko was talking about.

That is basically what we call a structure shortfall and out of Central Office. We use that as a base, and add to it the identified field shortfall of approximately $550 million.

Mr. **Steinberg**. Don, do you have anything you want to add to that?

Mr. **Thompson**. No, except that the task force did, after the initial meeting, go forward with a canvassing of each individual medical center to identify the shortfalls that exist in the field, as opposed to the residuals in Washington accounts. And that is how we came up with the figures that we gave you just a few minutes ago on our individual region shortfalls.

Mr. **Steinberg**. And that does not recognize the recurring shortfalls existing at medical centers caused by absorptions and reductions in previous fiscal years? I believe that is the $608 million figure which you previously clarified.

Mr. **Zamberlan**. That is my impression.

Mr. **Steinberg**. According to the task force report, an estimate of that figure—that is the accumulation of recurring shortfalls in the field caused by absorptions and reductions in previous fiscal years—was going to be available. Do you know whether or not such a figure has yet become available? That is, a national estimate for that?

Mr. **Zamberlan**. I am not familiar with it. I know there have been drafts of it. I think it is still a planning document, as far as I am concerned.

Mr. **Steinberg**. Dr. Gronvall, do you know if such a figure is available, of the nationwide total of recurring shortfalls caused by absorptions and reductions in prior fiscal years?

Dr. **Gronvall**. Based on the kind of survey that has just been described here, that has been cumulated for the Nation. It leads to a range of figures depending on what set of assumptions you use about which part of the shortfall you are talking about. But that information has been accumulated.

Mr. **Steinberg**. If you would provide that for the record, that would be very helpful.

[Subsequently, the Veterans' Administration furnished the following information:]

Regional Directors' analysis of fiscal year 1989 shortfall

	Millions
Deficit in "Bell Report"	$819.3
New requirements (HCMI, 89 FEHB, State home per diem and tuition reimbursement)	68.1
Congressional add-ons and actions	−87.6
CMD deferment of MEDIPP and contingency	−37.0
Subtotal	762.8
Prior year erosion of base (survey conducted by regional financial managers)	442.0
Total fiscal year 1989 shortfall	$1,204.8

Mr. **Steinberg.** I would like now to yield to Senator Murkowski.

Senator **Murkowski.** I apologize, but we have had South African hearings and three votes back to back; and those of you who observe the process here, I guess, are aware of it. But I feel apologetic in any instance because you people have come at great expenses and great distances in some cases, and you should be entitled to representation by the full committee.

But unfortunately, particularly on Friday afternoons, it is difficult. Those who are within striking distance of home, go home; and those of who can't possibly get there—for me, it takes me 13 hours one way—so I am here on Fridays.

Let me ask you if you believe that there is a need to examine the mission of the VA health-care system in terms of looking at every facility—and I don't mean that literally figuratively—to determine if it is basically needed. Is the mission such that perhaps redirecting it could increase efficiencies and result in decreases perhaps in monetary outlay? Are there possibilities for consolidation? I guess if the answer is in the negative, then can the VA afford to keep doing business as usual? We have seen—and you were here and heard earlier—that the budget has grown; whether it has offset the inflation rate is something that we can discuss.

Medical costs have gone up not only in the VA health-care system but outside the VA. So, can we keep doing business as usual or do we have to depart in an innovative role? If such an examination is recommended, how does it take place?

You know, the role of the veterans' organizations is an expansion of the status quo.

Mr. **Lindsey.** "Business as usual" is a phrase that you posed. To me the answer is: Of course not. If we have the same definition of "business as usual," it is almost like a——

Our system is dynamic. To survive, it must remain dynamic. We must change with the research. We must change with the literature. We must change with the training and education of the people that we hire. And we do that.

We have a process for that called MEDIPP. During the MEDIPP process, we look at the missions of the medical centers every year—an in-depth review of what they are doing and why they are doing it; and can we do it better and should we? And why not?

So, that process is under way now. Cost reduction is a part of that. Cost containment is a part of that. Mission is a part of that. Workload evaluation is a part of that. Quality of care is a part of that.

Where we put those few precious dollars remaining to get the biggest result is a part of that now. MEDIPP has become, I think, a process which we all believe in; but unfortunately, I think part of the $819 million shows a shortfall and our being implement MEDIPP initiatives.

Mr. **Thompson.** I am going to add to that that, in the last 4 years in our MEDIPP process, we have indeed looked at missions and have implemented over 200 separate initiatives at absolutely no increase in funding. In other words, we have made modifications within the missions of our facilities to generate the dollars that were used to implement those new programs.

We have also, in my region, and I think in others, utilized the concept in which we have nearby hospital missions altered to where they compliment one another so that we make certain that they don't compete with one another for the same types of patients and by doing the same types of workload.

This is, of course, to save in the investment of unnecessary duplicative equipment and things of that nature. But those efforts are under way. The possibilities of consolidation and like arrangements are certainly always there, but they have limits if you are required to maintain a certain ceiling and continue to operate in that manner.

Senator MURKOWSKI. Before we proceed, let me throw out a possible situation. Is there any merit—and you gentlemen are responsible for surgery in your different areas—if you would do away with a certain class of surgery? So, you wouldn't require the physicians to specialize in it; you wouldn't require the anesthesiologists or the other capabilities. Just contract that out. Is that conceptual—and say, for the sake of layman's knowledge—say cardiovascular type surgery? What is wrong with that kind of thinking?

Mr. WASHKO. For one thing, it would probably cost a great deal more.

Senator MURKOWSKI. You say probably, but if you do away with all the support that you need for that kind of surgery, for example—or some kind—you know better than I—is it more costly?

Mr. WASHKO. In the northeast region, I have a Board of Cardiovascular Advisers; we take a look at cardiovascular medicine, for example. And they have just given me a report that says that the VA costs for cardiovascular medicine are considerably less than the private sector.

As a matter of fact, they are less than half. So, I would conclude from that that it would cost the VA more to contract for cardiovascular medical care outside of the VA.

Senator MURKOWSKI. Please proceed with whatever other observations you were going to make before I interrupted you.

Mr. WASHKO. You asked about mission changes. Every year in our medical district initiated planning process, we review facility missions based on the current assumptions that we are making in our area. The planning board in the northeast, in taking a look at our current budget situation, has begun to develop some options for me to consider to forward to Washington which involved some fairly large mission changes and even some facility closure.

The thinking of the planning board, as they communicated it to me, is that they would prefer to have a smaller operation but do it well, rather than to have a larger operation and do it with either mediocrity or less.

Senator MURKOWSKI. Mr. Zamberlan?

Mr. ZAMBERLAN. I would agree with what my colleagues have said. MEDIPP has been and MEDIPP is very dynamic. In fact, I chaired a task force to revitalize MEDIPP for Dr. Gronvall this past year. Don Thompson and I shared that chairmanship, and one of the things we tried to do was to make it even more realistic and to tie it to the budget process, to try to bring the field input into the budget process. We talked about that earlier.

But I think that, until we do that and do it satisfactorily, until we get the field input on what we think our needs are in subsequent years, I think the budget process is not going to reflect what the real needs are in the field.

Also, when we talk about missions and mission changes and sharing, I think the VA has been proactive. We do an awful lot of sharing, joint ventures for example. Where the VA has a need for some type of service, a capacity—let's say MRIs—we need not buy them for ourselves. We could buy them jointly with partners, you know, in the community.

I have had an awful lot of that. We have had about seven of those just in region 4. So, I think all of that is part of our planning process.

In order for us to be a viable health delivery system, as Mr. Lindsay talked about, we have to review that. And I think the VA is open to changes that will make them more cost-effective and to continue to provide quality care.

Senator **Murkowski**. Thank you very much. Jon?

Mr. **Steinberg**. Thank you very much, Senator. I appreciate your courtesy in letting me have one or two more moments. You heard earlier the discussion that we had with the field panel about whether or not the options that are being considered should be implemented nationally or should be left to some regional or facility discretion.

The question I have for you, which hopefully you can answer with one or two words, is: Do you believe that these options that are being looked at in the Chief Medical Director's report should be implemented on a nationwide basis as selected by DM&S? Or do you believe that discretion should be given to regional directors or facility directors to select among an approved list of options?

Let me start with Mr. Lindsey.

Mr. **Lindsey**. I will try that.

Mr. **Steinberg**. Try it very, very briefly.

Mr. **Lindsey**. Yes. Under my philosophy, decisionmaking ought to be at the lowest practical level. I am sure that there are some of those options which the CMD may choose to select which should be at the medical center level. There probably would be some at the RD level and others at the national level.

I would hesitate to think that all decisions would be made at just one level.

Mr. **Steinberg**. You think there should be a mix?

Mr. **Lindsey**. A mix.

Mr. **Steinberg**. With some discretion. Do each of you agree with that essentially?

Mr. **Zamberlan**. I certainly would.

Mr. **Steinberg**. All right. Finally, you also heard the discussion we had with the Administrator with respect to the possibility of a supplemental for fiscal year 1989 and the discussion we had about the timing of that, and the Administrator's pledge that he was going to do everything he could to try to get a request so the Congress could act upon it this month.

Could you very briefly indicate to us whether or not it would be a serious problem for you were the supplemental money to become available next year—and the earliest realistically would be February or March before anything could be enacted—as contrasted with having the money at the start of the fiscal year?

Let's start with Mr. Zamberlan very, very briefly, please.

Mr. **Zamberlan**. I would agree with the comment that the Administrator made earlier. The sooner we have the money, the better that we can position ourselves. The earlier we get it, obviously we are going to be in a better position.

I think as far as February is concerned, if we knew that, then we could position ourselves for it. Right now, I know that all of us were talking about this just yesterday; we are starting to position ourselves so that if we actually won't receive a supplemental. And that means that we have employment levels right now that are below that ceiling that all of us are concerned about it, and also looking at starting to reduce the workloads because we are not sure that that supplemental is coming.

But if it does come, I am sure that we can adjust to do it in a manner that we can just reverse the gears, and I am sure we wouldn't wrench the system.

Mr. **Steinberg**. Do any of you have anything to add to what Mr. Zamberlan said?

Mr. **Lindsey**. I do. Another part of it, of course, is that when the Administrator can do so, to inform us of what is in that supplemental so that we can gauge our strategies to match those dollars which might be forthcoming.

Mr. **Steinberg**. The point, of course, is that it only might be forthcoming because, as the Administrator indicated and as Senator Cranston indicated, there are no certainties; and it is not going to be an easy task to get that money.

Mr. Thompson?

Mr. **Thompson**. We would clearly have to begin the fiscal year with diversions of dollars. They would have to begin diverting from nonrecurring accounts on day one. So, the farther we go into the year, the more diversions will have occurred by the time we know whether we are going to have a supplemental or not.

Mr. **Steinberg**. Then the more the problem that you indicated earlier, Bob.

Mr. **Lindsey**. The problem is even more significant then than the diversion of nonrecurring M&R resources. Then, I think we have to take a hard look at the balance of where we put the dollars, the balance between FTEE, all other accounts, and workload. That will depend upon what the chances are for the supplemental; but to go into the fiscal year only with a diversion of nonrecurring resources may not be the best strategy for us.

We may have to bite a hard bullet and then recommend to our bosses a different mix between FTEE, workload, and all of the resources so that we have the proper balance to meet whatever workload we can achieve.

Mr. **Steinberg**. Thank you all very much. We will have some written questions to submit.

I thank Senator Murkowski again. On behalf of Senator Cranston, I want to especially express his appreciation to all of those from the VA, to the Administrator, to Dr. Gronvall, to Dr. Winship, to Allen Jones, and to many others who have remained with us throughout this hearing. We are very grateful for your participation and for your being here to hear what the field has to say which, after all, was one of the principal purposes of this hearing.

We will be rescheduling the other six witnesses that were postponed from this hearing, and again we thank you all very much. Thank you, Senator.

Senator **Murkowski**. Thank you, Jon. I want to join in Jon's remarks concerning the commitment of the witnesses. Many of you who are in the audience participated in spirit, and I am sure that we would like to hear your opinions as well; but oftentimes, as is the case today, we do have more witnesses than we can accommodate and oftentimes get somewhat carried away with the questions and the opening statements.

But that is the reality of Washington, DC and the U.S. Senate.

Let me wind up by indicating that I think this hearing has been valuable, not in the sense of creating a reaction of a crisis in the quality of medical care; but the expression of concern, as highlighted by the experts that are responsible for carrying out and committed to professional quality care and the dedication that they have shown toward that commitment by their comments and recommendations today.

And to the service organizations, who continually bring to the forefront the shortcomings of what, in an ideal world, would be a situation where we could hold a hearing and hear nothing but praise—that everything was "hunky-dorey"; but that isn't the real world either.

So, we have this counterbalance, and that is what the democratic system is all about. It is a cleansing action, a commitment in good faith, as evidenced by all parties. I think that leads us to move onward and address the problems, address the problems with a concern of the Senate and the Congress as a whole in the manner in which we respond to a crisis of money management, where in the last year we have had three supplementals.

So, as we reflect on the status of health care, we must be reminded that there was $1.129 billion in VA supplementals this year; $600 million were in loan guarantees, $498 million in compensating COLAs, and $31 million in the medical account Public Law 100-322.

Now, that is not to suggest that that is the way to do business; but it is the way to address a situation where we have to meet the obligation and can do it in a monetary sense. I think personally that, as a consequence of this hearing and other hearings that Senator Cranston and I will participate in, in the sense of trying to develop responses to the changing needs of veterans, that through the input of those witnesses today and others who will testify, we can do a better job with what we have in regard to the changing needs of the veterans.

It is going to take some innovation. We have the budget realities, which we are continually faced with. We have the message very clear from the professionals that they are up to "here" and can't go any further because, if you go any further, you begin to go down here. It is just like getting in deep water, and we are in that deep water; and we are going to have to figure out just how to resolve it.

That resolve can best come from the recommendations of people who are committed and dedicated.

I want to thank General Turnage for his response, and I think he, too, would agree that this hearing has been invaluable in the sense of the communication and will result in a cleansing and a reexamination of the VA process, as is appropriate.

It will give us an opportunity to review in the record the specific instances where veterans are not being served in the manner in which they should; where, if there are any substantial increases in documented cases where care has not been given, they can be identified and corrected.

This is again a part of the process. So, while there have been times when I am sure there have been some unspoken thoughts on both sides of the issue, it has been a healthy process. I think Dr. Gronvall and his staff, who have remained through the hearing, have found the discussion to be beneficial.

And I think it leads one to a realization that we all join in our commitment to veterans. It is displayed by the openness that has occurred in this committee, the straightforwardness, and the continued commitment to work with Congress on this very important issue and obligation of our Nation.

So, I thank all of you on behalf of Chairman Cranston, and I do apologize that we were unable to accommodate the entire witness list. With that, I believe the hearing record will be open for 1 full week from today. And it is my understanding that the chairman will be scheduling another hearing to accommodate the seven witnesses who were unable to testify today because of time constraints.

I wish you a good day. Thank you, ladies and gentlemen; and thank you, Jon and Alan, and your respective staff support groups.

[Whereupon, at 2:28 p.m., the hearing was recessed, to be reconvened on September 20, 1988.]

ADEQUACY OF VA FUNDING

TUESDAY, SEPTEMBER 20, 1988

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to recess, at 10:03 a.m., in room SR-418, Russell Senate Office Building, Hon. Alan Cranston (chairman of the committee) presiding.

Present: Senators Cranston, Graham, Murkowski, Thurmond, and Specter.

OPENING STATEMENT OF CHAIRMAN CRANSTON

Chairman **CRANSTON**. The hearing will come to order. Welcome to this morning's continuation of our September 9, 6½ hour hearing on the adequacy of VA funding and personnel resources to meet current and future needs of patients seeking care from the VA health-care system, I especially want to thank today's witnesses for returning. I apologize for any inconvenience the postponement may have caused you.

Unfortunately, Dr. Beaty, representing the American Association of Medical Colleges, was unable to return. His written testimony will, as will the testimony of all witnesses today, be printed in the record.

[The prepared statement of Dr. Beaty appears on p. 475.]

Chairman **CRANSTON**. The testimony that we received under oath on September 9 painted a clear and very disturbing picture of the severity of the problems being faced by the VA health-care system, of the adverse effects on patient care due to the unavailability of services, and of some of the alternatives which are available to resolve this crisis.

All the field witnesses we heard testified under oath that the current situation is a crisis and is the worst financial crisis that they have ever seen in the VA. I am certain that today's panel made up of different organizations having a strong tie to and interest in VA health care will give us further valuable information.

On September 9, the Chief Medical Director testified that a good estimate of the VA shortfall for fiscal year 1989 is $608 million. The medical center directors and chiefs of staff testified that they felt that they would need to cut back substantially on health-care services unless relief was forthcoming.

Administrator Turnage testified that he had sent a supplemental appropriations request to OMB and that he would do everything within his power, including appealing directly to the President if that was necessary, to obtain timely administration action on the request.

Since that hearing, we have learned that the fiscal year 1988 base has been eroded by an additional $440 million due to the redirecting of funds from accounts for such things as equipment and maintenance and repair, which has been occurring for several years. Hence, the true shortfall, according to estimates in the Department of Medicine and Surgery at Central Office, is well over $1 billion to continue current workloads and comply with applicable law.

In followup to the Administrator's pledge, I wrote to him on September 13, emphasizing two vitally important matters: First, that the amount of any supplemental request must be sufficient to enable the VA in fiscal year 1989 to maintain current service levels and comply with all applicable laws; and, second, that action is necessary to produce an administration request that can be considered by the House Appropriations committee when and if it marks up the fiscal year 1989 continuing resolution. We will print that letter and any reply we receive in the hearing record.

[The letter appears on p. 360.]

Chairman CRANSTON. For example, if the VA is seeking additional funding only for the purpose of covering the fiscal year 1989 costs of implementing the mandatory provisions of Public Law 100-322, estimated at $117 million, the request would be woefully short of the amount needed to maintain current services. In that event, options such as those mentioned in the task force report, including many dire ones, may very well become realities.

I also stressed to the Administrator OMB's track record for not acting promptly upon supplemental requests. And in order for a fiscal year 1989 VA supplemental request to be enacted during this Congress, which is expected to adjourn before or during the second week of October, OMB must send the request forward and do so in the very near future in order to prevent substantial reductions in VA health care. In the absence of such a request, it is highly unlikely that we will be able to provide the VA with additional medical care account funds for fiscal year 1989, as we did for fiscal year 1988 as a result of my amendment to the dire urgent supplemental of August 4.

If the possibility of a supplemental appropriation is put off until next year, at least 4 months of fiscal year 1989 will have already elapsed and drastic reductions in services would have had to have been made by then.

I hope that Administrator Turnage has taken all the steps he said he would, including going to the President, to obtain the funding that the VA health-care system desperately needs and that veterans are entitled to. I will continue in my efforts to do so.

And, finally, I want to note the presence here of Dr. Daniel Winship, the VA's Assistant Deputy Chief Medical Director, representing both the Administrator and Chief Medical Director Gronvall, both of whom remained with us throughout the September 9 hearing. Thank you all very much. Now we will hear from you, Frank.

OPENING STATEMENT OF SENATOR MURKOWSKI

Senator **Murkowski**. Thank you, Mr. Chairman. Good morning. I join with my colleague from California in welcoming our witnesses again today. I commend you, Mr. Chairman, for fulfilling your commitment to continue the hearing which began on September 9. I join with you in regretting that time did not permit us to hear the distinguished group of individuals during that September hearing. We regret the inconvenience that may have been caused. But, in any event, we thank you for being here today.

As representatives of VA employees, today's witnesses have, I think, a unique perspective on the situation at our VA hospitals. As was discussed in the September hearing, the funding and staffing situation within the VA medical-care system is tight. There is no disagreement whatsoever on that point. And the question is very real: How do we come to grips with that shortage when facing the reality of limited Federal dollars.

I happen to believe that agreement on this question is not going to be easily achieved and we have to recognize a few facts. Fact one, we can never properly repay the obligation which we have as a Nation to those who gave so much on behalf of our freedom and liberty. A second fact is, we will never have enough funds to adequately do the job and meet that obligation. That has been a fact in previous years; it is a fact this year; it is going to be a fact next year. What we need to hear from you people, who are experts in the field, is how we can continue to become more efficient and recognize the changing needs of America's veterans. They are growing older and medical-care requirements are changing as well.

Can we continue to do all things within the VA or are we going to have to consider contracting outside the VA as these needs change. The age of our veterans requires care in convalescent homes and care within the residence of the veterans. We have never had a provision for the payment of nurses in the home. And these are ideas that I think we can best look to you for advice and opinions as we recognize the self-evident fact concerning our obligation and the reality of funding.

We appreciate your commitment to serving veterans and your willingness to participate in the hearing. I, along with my colleagues, look forward to your testimony. Unfortunately, I am going to be leaving very shortly for a hearing with the Energy Committee. I am going to be hearing about some trends which may or may not have some long-range impact on veterans as well as everybody else's world.

Thank you, Mr. Chairman.

Chairman **Cranston**. Thank you very much, Frank.

Strom, do you have an opening statement?

Senator **Thurmond**. I don't have any opening statement. Thank you, Mr. Chairman.

Chairman **Cranston**. Thank you.

Our panelists this morning have an incredible amount of experience working in many aspects of health care and in connection with the VA.

Let me first introduce Dr. Roger Des Prez, President, Association of Veterans' Administration Chiefs of Medicine and Chief of the

Medical Service at the Nashville VA Medical Center; Dr. Thomas Kiernan, Member of the National Association of the VA Chiefs of Staff and Chief of Staff at the Huntington, WV VA Medical Center; Miss Claudette Morrissey, R.N., President, Nurses Organization of the VA and Staff Nurse, Brooklyn VAMC; Dr. Paul W. Schafer, Executive Director, National Association of VA Physicians and Chief of Thoracic Surgery at the Washington, DC VAMC; Mr. John Sturdivant, National President, American Federation of Government Employees, accompanied by Miss Mary McCarte, President, AFGE, Local 3669; and Miss Marie Winslow, Legislative Liaison, National Federation of Federal Employees

Good day to each of you. I thank you again for agreeing to return today to testify before us.

John Sturdivant, I congratulate you once again on your recent election as National President of AFGE. And I will ask you to lead off after the panel is sworn in. But if you would please rise first, I will give the oath.

[Whereupon, the panelists were duly sworn by Chairman Cranston.]

Chairman CRANSTON. Thank you very much.

John, if you would now proceed.

STATEMENT OF JOHN N. STURDIVANT, NATIONAL PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, ACCOMPANIED BY MARY McCARTE, PRESIDENT, AFGE LOCAL 3669, MINNEAPOLIS VA MEDICAL CENTER

Mr. STURDIVANT. Thank you, Mr. Chairman. My name is John Sturdivant. I am the National President of the American Federation of Government Employees. Accompanying me is Mary McCarte, President of Local 3669, Minneapolis VA Hospital.

We represent some 700,000 Federal employees nationwide, including 19,000 professional and 102,000 nonprofessional employees in the Veterans' Administration.

In my discussions with VA workers across this country, I have found the following statements to be true for VA health-care workers in every occupation and profession, in VA facilities of every size: morale is at an all-time low; employees are overworked and underpaid; job-related stress is bad and getting worse; all too often management seems indifferent to the VA's mission.

And I would just say that the specifics that were given to you at the previous hearing about the service organizations could have just highlighted this subject by its members.

The bottom line for these workers is that dedication, commitment and plain old-fashioned hard work can relieve only a small amount of the desperation these employees feel about their working conditions and the impact those conditions have on veterans care.

I know that I speak for every VA employee when I say that the care and well-being of the men and women who served our Nation are in jeopardy every day these conditions are permitted to continue unabated.

On behalf of VA employees, I urge this committee to do everything in its power to alleviate this current crisis by restoring the necessary funding and resources to the Veterans' Administration.

Perhaps the most telling statistic revealing the extent of the overall personnel crisis is the separation rate for the Veterans' Administration. In fiscal year 1987, 27.76 percent of the VA employees—or 68,361 workers—left the Veterans' Administration for other employment or retirement. That rate was higher than any Cabinet level Department except the Department of Agriculture, and it was 47 percent higher than the average rate for executive departments.

And this astonishing separation rate shows no signs of diminishing. Through the first 8 months of this fiscal year VA's turnover rate was 16. 01 percent, which project: to an annual 24 percent rate.

These turnover numbers mean that every 4 years it is as though the VA has an entirely new work force. So it is difficult to see how Administrator Turnage can claim, as we: read in the Washington Times, that the VA "gets all we need to do our job well," when he cannot recruit and retain the personnel he needs to get the job done. Nonetheless, these cold sterile statistics cannot fully explain the anguish of the employees charged with making life and death decisions every hour of their workday. We will never hear from these statistics about the nurse in the Minneapolis VA Medical Center who says she "prays I don't goof" as she hurries from one crisis to another.

Finally, the numbers do not show the danger VA employees constantly face when even a single, accidental needle stick can lead to a dreadful incurable disease. And I would certainly sound a cautionary note when we start talking about contracting for care. Under the contracting for care proposal there is no control over the care, it has not been shown to be cheaper, and the institutional memory that is needed to provide the care for these veterans is lost.

Further, in the area of direct care to veterans our members express great concern over the new resource allocation management system. In particular, the use of rigid predetermined treatment times for particular illnesses or injuries is causing problems. In other words, it is all right if you get sick, but you have to do it on schedule. Our members report that in all too many individual cases, veterans are being released from the medical centers to meet these predetermined schedules rather than meeting the health needs of the individual veterans. We urge the committee to maintain close oversight of the implementation of this program.

We want to bring to the committee's attention two other recent actions which are disrupting VA personnel relations and are having a serious impact on the ability to recruit and retain needed personnel.

By far, the most serious action is the decision in the Colorado Nurses Association case which effectively strips collective bargaining from title 38 personnel. Our locals are reporting that for many of your title 38 members this will be the straw that breaks the camel's back. While their commitment to the VA and veterans' care has kept them on the VA staff for many years through difficulties, they are now asking why they shouldn't go across the road to State, local, charitable or for profit hospitals and earn more money, experience less stress, get better health benefits and have the protection of a collective bargaining agreement.

Have no doubt about it. Without legislative redress to restore the status quo, current recruitment and retention problems will worsen.

In that regard, let me express our appreciation to you, Mr. Chairman, and to Senator Murkowski for their letter to Administrator Turnage urging that he maintain the status quo in our collective bargaining procedure.

Finally, this committee has been in the forefront of defending quality health care for U.S. veterans. As part of your commitment to veterans, this committee and the Congress in recognition of the severe staffing problems of registered nurses in the VA, authorized 25 percent premium pay for Saturday work for RNs. Unintentionally, this has created a good deal of resentment among the VA personnel not eligible for Saturday premium pay.

Therefore, we support section 4 of H.R. 5114, which would include nursing assistants.

We thank you for your assistance in this area and I thank you for the opportunity to present these views. And I would be most happy to answer any questions that you might have. Thank you.

Chairman CRANSTON. Thank you very much, John.

Dr. Des Prez.

[The prepared statement of Mr. Sturdivant appears on p. 362.]

STATEMENT OF DR. ROGER DES PREZ, PRESIDENT, ASSOCIATION OF VETERANS' ADMINISTRATION CHIEFS OF MEDICINE, AND CHIEF, MEDICAL SERVICE, NASHVILLE VA MEDICAL CENTER

Dr. DES PREZ. I am Roger Des Prez and I represent the association of VA Chiefs of Medicine, or AVACOM. I am grateful to have been invited to testify last week, but also grateful that I didn't get to talk as the witnesses made the funding crisis in the VA quite clear and I will not enlarge on that.

In my personal view, it is at least 2 years old. Before that, we always had enough to do business, although less than we thought we needed. We got caught in a convergence of increasing workload, increasingly expensive and complex medicine and no increase in budget. What I want to address today is the effects of that crisis on medical services.

Chiefs of Medicine are in the profession of trying to provide the best quality of medical care. The gratification of doing medicine well, and in many instances teaching it is why we are in the VA in the first place. But the present shortage of funds has compromised the quality of our care; and this is demoralizing our entire medical structure. We have first rate cardiologists. But when delays due to constricted resources result in a bad patient outcome, or lack of coronary care facilities make it necessary to transfer the patient to a non-VA facility, it ceases to be enjoyable to do cardiology at the VA.

We have first-rate oncologist, but when lack of sophisticated imaging equipment makes it impossible for them to do good oncology, they get dissatisfied.

We have first-rank gastroenterologists—and, incidentally, gastroenterology is very cost-efficient, since with their tubes and mirrors they can do things which only a little time ago required surgery—but when their equipment and staff are inadequate they find it no longer attractive to stay with us at literally a fraction of the income they can generate in the private sector.

Many of our hospitals—somewhat more than half—are training hospitals with house staff. In these, the demoralizing effects of limited resources are really very destructive. House staff are mostly wonderful doctors. They are very serious about what they do, very serious about giving the best possible care to their patients, very serious about preparing for the rest of their lives. They, like nurses, care intensely. The demoralization which results from limitation of resources is disproportionately great for them because they feel so intensely and try so hard. The harmful impact of the nursing shortage on our hospitals about which I presented some quantitative data in my written testimony last week is multiplied since it frustrates and discourages not only the nurses but the doctors who work with them.

Our membership agrees with General Turnage that category A patients are generally not denied hospital admission. But what we can do for them, the quality of their care, is compromised by inadequate resources.

Quality of care is difficult to define, but one essential factor or attitude is the belief on the part of the provider that that is in fact what he or she is doing. Thus, a crisis in funding in the VA hospital system, so well documented last week, cuts at the very roots of the quality of care provided in Veterans' Administration hospitals.

Finally, I would like to say a few words about AIDS. First, Dr. Norton Spritz of the Manhattan VA has asked me to express his regrets that he cannot be here this morning. I have put his testimony from last week out on the table again and my remarks are based largely on conversations with him.

[The prepared statement of Dr. Spritz appears on p. 495.]

Dr. Des Prez. First, AIDS is a problem which is not optional and will only get worse. Actually the increase in AIDS in the VA will probably be greater than in the country at large as the ability to care for these patients in the non-VA sector become saturated and veteran AIDS patients are transferred to our hospitals.

Although the response to AIDS at present has been to protect the funding of those hospitals with the largest number of AIDS patients, it does not represent new money to the entire system and therefore resources devoted to AIDS must be diverted from other needs which are themselves overfunded. We are very proud of the Agency's response to AIDS, and especially proud of certain efforts, such as at the Manhattan VA, where a special center of compassionate understanding for these desperately ill young men has been created. But we do believe that AIDS merits special consideration at the congressional level so that resources for it do not have to be carved out of more general and already inadequate funds.

Thank you very much. I will be happy to answer any questions.

Chairman **Cranston**. Thank you, Doctor, very much. Dr. Kiernan.

[The prepared statement of Dr. Des Prez appears on p. 384.]

STATEMENT OF DR. THOMAS W. KIERNAN, MEMBER, NATIONAL ASSOCIATION OF VETERANS' ADMINISTRATION CHIEFS OF STAFF

Dr. **Kiernan**. Thank you, Senator Cranston. I am Dr. Tom Kiernan, Chief of Staff at the VA Medical Center in Huntington, WV, and I am substituting this morning for Dr. Wendell Musser, President-Elect of the National Association of VA Chiefs of Staff. I am a member of that organization.

Dr. Musser's written statement of September 9 was given to the committee and I have no written statement to add to that.

[The prepared statement of Dr. Musser appears on p. 407.]

Dr. **Kiernan**. I would like, however, this morning to summarize some of the high points of Dr. Musser's statement and provide a few personal observations.

To answer your question of last week, Senator Cranston, "do we have a crisis?" Yes, we do have a crisis in VA health-care delivery this year. we are at the point of serious imbalance where patient care imperatives, which require a quality of care, are becoming imbalanced by a shortage of allocated resources. That was described as being "tight"; I think it is worse than tight.

We are now at the brink of losing quality. We have maintained quality today by, unfortunately, consuming valuable dollars from other resources. Some of our medical centers are using nonrecurring maintenance funds, construction funds and equipment funds to support the needs to take care of patients. Yet we remain antideficient at our medical centers.

We fear fiscal year 1989. We know the mandates that come with Public Law 100–322 and the partially funded pay raise. We know there will be a serious shortfall. We are well aware of Dr. Gronvall's task force—the so-called Bell Task Force—to look at recommendations whereby we might cope with the shortfall.

I see that we are going to have to go toward downsizing. However, we await the CMD's recommendations.

The crisis brings a dilemma for us as clinicians. We are disturbed at the potential loss of the high quality of care that we have been so proud of, in giving good services to our veterans. We are also disturbed by the parasitizing of nonconventional funds, as mentioned before, because it will have a toll on the status of our buildings and our ability to provide efficient patient care.

General Turnage told us last week that he had submitted a request for a supplemental and we hope for relief from that. We support the initiatives in our Agency for short-term remedies for fiscal year 1989, and we also support the plan to try to develop some kind of a plan for the next several years to interrupt this shortfall of funding that has plagued us now for 10 to 12 years.

We delight at the proposed elevation of the VA to Cabinet status, particularly because a Secretary of Veterans' Affairs can give greater visibility to the Veterans' Administration. The Secretary will be able to show where the VA fits better into the U.S. health-care scene, and can reveal to the President and others the problems and the challenges that face the VA in helping its veterans.

I speak for my colleagues today and myself when I say we are, nonetheless, dedicated to a quality of patient care for veterans. We are supporting continuance of the VA as an excellent health-care, professional, and educational environment. We support relevant and sophisticated medical research and we are ready to provide support to the Department of Defense in time of war.

If there are any questions I would be happy to answer them. Thank you, sir.

Chairman CRANSTON. Thank you very much. We appreciate your testimony. Miss Morrissey?

STATEMENT OF CLAUDETTE MORRISSEY, PRESIDENT, NURSES ORGANIZATION OF THE VETERANS' ADMINISTRATION, AND STAFF NURSE, BROOKLYN VA MEDICAL CENTER

Ms. MORRISSEY. Mr. Chairman, I am Claudette Morrissey, a registered nurse employed full-time as a staff nurse at the Veterans' Administration Medical Center in Brooklyn, NY. I am here today as the President of the Nurses Organization of the Veterans' Administration. NOVA thanks you, Mr. Chairman, for holding these hearings on the adequacy of resources to provide for quality patient care on a timely basis.

The question you have asked NOVA to address today is a difficult one. The answer touches the heart and conscience of VA nurses throughout the country as each nurse strives daily to provide quality care to the veteran patients who seek and deserve that care.

In a recent poll, NOVA asked VA nurses across the country, "Are there sufficient resources to recruit and retain qualified nurses?" The answer we received from 83 percent of those who responded was a resounding "no. " The nursing shortage that NOVA has discussed before this committee in the past has moved beyond the urban centers on each coast and is evident now throughout the Nation.

Recruitment of nursing staff is severely hampered because VA hospitals are not competitive with community hospitals, and salaries for the entry level nurse or for the highly qualified experienced nurse.

VA informs us that they have little or no money available to advertise and attract applicants. Nurses throughout the country tell NOVA that the nursing FTEE have been cut at their facilities. When nursing positions are vacant because of recruitment difficulties, and the hospital budget requires that positions be eliminated, those empty nursing slots are sacrificed and the nursing ceiling is reduced or frozen at a lower level. This increases the workload to the point where remaining nurses must work so fast and furiously that the likelihood of a life threatening mistake increases significantly.

Nurses are not afraid of hard work. What we do fear is that harm will come to a patient because we are unable to give them the nursing care they need. NOVA has stated in the past that overworked nurses are poor recruiters for the VA system. Retention of nurses already working needs to be of a concern, for a cadre of satisfied, enthusiastic, competent and caring nurses will be our best recruiters for the future.

The issues involving retention of nurses are very closely related to those of recruitment. NOVA is alarmed to hear nurses with 14 and 15 years of VA experience are leaving to work elsewhere.

The ability to provide patient care is severely compromised when there are not enough nurses. It is common that the number of hours of patient care far exceeds the number of staff hours available to provide that care.

In the previously stated poll, 82 percent of the nurses said "yes" when asked if supplies were inadequate. Some of the most common shortages include sterile 4 by 4s and 4 by 8s for dressing, urinals, syringes, Swan Ganz catheters, water pitchers, and soap. IV solutions and common medications are also often out of stock. Now out of stock items may seem like a simple inventory problem, but there is an effect on patients, nurses, and physicians.

For example, when a particular IV solution is not available nurses need to call or find a physician to rewrite the doctors orders for all the patients for whom that solution was ordered. This process absorbs the time of the physician and the nurse and deprives the veteran patient of their attention as well as the first choice in medication.

In the name of budget constraints, nurses report poor quality supplies are often substituted for those requested or recommended by nursing and medical staff.

Many report that no new replacement equipment has been bought in over a year, and that equipment dollars have been used to pay salaries. When equipment such as electric beds, infusion pumps, defibrilators, hydraulic lifts, and wheel chairs are not available the quality of patient care suffers.

When NOVA hears similar reports from throughout the country it seems clear that departments everywhere are shifting, juggling and trying and trying to survive in a system that is inadequately funded for the legislative mission. When there is shortages in other departments, nurses are required to fill in the gaps as respiratory therapists, ward secretaries, and housekeepers. When nurses are used as the all purpose disposable employee, patients are deprived of nursing care and nurses get used up.

What is needed now is action.

In conclusion, a summary of the five most important steps needed are:

Work schedules should require minimal rotation and more weekends off, and staffing should be appropriate to the workload.

Salaries should be comparable to the private sector. And we urge that Congress adopt special incentive pay for nurses. Presently 118 facilities are on special salary rates. Twelve of those are at the maximum for junior grade. This maximum step 19 is $5,000 less than the community rate for similar nurses.

Title 38, section 4107(g) provides that "The Administrator" may set up special salary rates for personnel with specialized skills so that maximum rates for grades may be increased." This waiver is urgently needed in nursing for registered nurses have specialized skills that are urgently needed.

The nurses of the Veterans' Administration belong strongly in the mission of our Agency, and ask that when you legislate our mission please legislate to give us the resources to fulfill it.

Thank you, Mr. Chairman. I will be happy to answer any questions.

Chairman CRANSTON. Thank you very much.

Dr. Schafer.

[The prepared statement of Ms. Morrissey appears on p. 412.]

STATEMENT OF DR. PAUL W. SCHAFER, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF VA PHYSICIANS, AND CHIEF OF THORACIC SURGERY, WASHINGTON VA MEDICAL CENTER

Dr. SCHAFER. Mr. Chairman, as I have listened to the information brought forth by these hearings I have been struck by the voluminous detail in which the budget crisis has been defined. One can only be amazed that Agency leadership refuses to face this reality. The testimony which I have submitted adds to this bill of particulars. It also casts light on perhaps the most devastating feature of the situation: namely, VA health-care providers each day wonder what next will befall this once wonderful system which provided first-class, high-quality care for veterans. They question if we are not moving to a time when the practice of medicine for veterans will be validly regarded as second or even third-class.

Over the weekend it occurred to me that I should share with you a sample of recent letters received at NAVAP headquarters. They leave little doubt that the program's very existence is threatened. I request that these documents be added to my submitted testimony.

[The documents appear on p. 443.]

Dr. SCHAFER. Received September 9 from the Hines VAMC in Chicago, Dr. Armand Littman and his staff describe the deplorable state of outmoded equipment at that facility. In this letter, dated August 20, Dr. Alex Raney tells of the alarming state of affairs at Wilmington, DE VAMC. Permit me to read just a portion of his letter.

> 1. The Chief of Nuclear Medicine and all of his staff departed for better pay in the private sector and the service has shut down completely;
> 2. The Chief of Cardiology left for private practice;
> 3. The Chief of ENT left for twice as much salary in the private sector and that service is in the process of being shut down;
> 4. The Chief of Nursing Education resigned;
> 5. A full-time orthopedic surgeon left and the entire orthopedic service is slated to be closed;
> 6. The Chief of Surgery just resigned this month to go into private practice;
> 7. The maxillofacial and podiatry services are being phased out arbitrarily;
> 8. The loss of nurses and technicians to the private sector for better pay has crippled our laboratory, x-ray, and nursing services;
>
> And, finally, the losses represented by those competent and hard-working employees who are looking for better opportunities and jobs in the private sector are incalculable and beyond the description of this communication.
>
> As the enclosed memorandum, which is filed with the dean of the medical school, stated so clearly, if the situation does not change by October 1988, the residency program at this hospital may be terminated. In my opinion, it is obvious that without resident house staff, this teaching hospital could not survive. This message only signals the beginning of the end for this active VA center in this State and perhaps for the rest of the country as well.
>
> It is ironic to think that in this election year, all the presidential candidates hug and embrace our veterans, but no one addresses their health care in the various VA hospitals around the country!

Mr. Chairman, can you fault a young man or woman physician who plans for a career elsewhere than in the veterans' medical program? And that, my friends, is the challenge which, together, we face. How to turn this thing around? And maybe the time of Veterans' Affairs being elevated to the Cabinet level is the time to do it:

There has to be more money;

Effective management practices must be put in place. Too many inept cooks spoil the broth;

Section 4108, title 38 United States Code with its unfettered delegation of authority must be replaced by modern personnel policy structures;

And the new Department of Veterans' Affairs must have leadership of character and competence akin to that of the Bradley, Hawley, Magnuson triumvirate and the early CMDs who followed.

And now you might ask, if things are as bad as they seem why even try for a fix? And the answer to that question is that most of what ails the veterans' medical program is but a reflection of the larger society in which we live.

We need to make every effort to have the VA health-care delivery system live up to its promise because it has the potential for becoming one of the models which America must have if we are to meet the unmet health-care needs of all of our citizens.

In our pluralistic society some of its features may be found more attractive than those of the failing HMOs of the private sector, the insurance companys' money machines or the health-care enforcement plans of corporate America.

Thank you, sir.

Chairman CRANSTON. Thank you very much. Miss Winslow.

[The prepared statement of Dr. Schafer appears on p. 424.]

STATEMENT OF MARIE WINSLOW, LEGISLATIVE LIAISON, NATIONAL FEDERATION OF FEDERAL EMPLOYEES

Ms. WINSLOW. Good morning, Mr. Chairman. On behalf of the National Federation of Federal Employees, which represents 14,000 employees of the VA, most of whom work at VA hospitals and outpatient clinics, I appreciate the opportunity to appear here today. I am going to ask that my statement be included in the record and I will just summarize it because many of the points that I intended to make have been made by others already.

Chairman CRANSTON. It will go in the record as will other statements.

Ms. WINSLOW. Thank you.

I would like to center my remarks on four main points. A pattern seems to be developing with the VA concerning training, overtime, premium pay, and staffing decisions. Mr. Sturdivant spoke about premium pay, the discrepancy between the premium available for RNs, who are title 38, and the title 5 employees, who are LPNs, et cetera.

Right now, a VA administrator can provide premium pay for title 5 employees but only when he or she can demonstrate that a severe recruitment and retention problem exists at his or her hospital. We feel that this is far too great a constraint to put on a VA administrator, and that they should be able to preclude a severe recruitment and retention problem by making premium pay available to title 5 employees.

Insofar as overtime is concerned, we feel that this stems directly from staffing insufficiencies. There are not enough medical employees hired in order to cover the potential for leave, both annual and sick leave. We find that our employees have to work overtime because there is no one else there to take care of the patients. And this is also affected by the long shifts.

VA medical employees often work 10- and 12-hour shifts. Now our members feel that if there was sufficient staffing to prevent this constant overtime, or if the shifts were shorter, the situation might work, but the combination of constant overtime and 12-hour shifts is sapping the energy of the employees, the health of the employees, and certainly affecting the care that the VA patients are receiving.

The last thing I would like to mention is training. In-service training, according to our members, is a joke. This refers to the specialized training that is available on the job for certain types of equipment.

Mr. Chairman, with the kind of medicine that is practiced in a VA hospital, it is not just enough to assign a nurse to take care of a patient. When the nurse cannot attend the in-service training for that patient because she is the only RN on the ward, how is she going to take care of that patient? When she ordinarily works in ICU and is suddenly handed a patient who has a condition she is unfamiliar with, Mr. Chairman, she worries about malpractice if something happens on her watch. And she hopes it doesn't because she really is not trained to take care of these people.

I would just like to mention a situation that I found troubling when I was researching for this statement.

We have a VA hospital in Fargo, ND, which is not a place that captures a lot of people's attention. But Fargo is a very good example of the hospital system that is in a serious decline. They have lost seven registered nurses in the past 2 months. A surgical unit with about 25 beds was closed in July because there wasn't enough personnel to keep it open. There is a 6-month waiting list for non emergency surgical procedures. The nurse anesthetist who helps in the administration of anesthesia has been assigned the additional and essentially unrelated chore of post-operative duties. They have contracted out the chief radiologist position. They don't have an EKG chief. The physician in charge of gastroenterology left. I don't think we need a crystal ball to see what is going to happen if something very serious isn't changed in Fargo, ND.

The VA health-care system's first concern should be quality care for the veterans, and in that respect the Agency is failing. Morale is low; turnover is rampant; personnel are working 20 hours in a row; and veterans are turned away because there are no nurses to staff the empty beds.

We are confident that this committee will be able to help address these problems and we look forward to working with the committee in that respect. I will be happy to answer any questions.

Chairman CRANSTON. Thank you very, very much.

[The prepared statement of Ms. Winslow appears on p. 452.]

Chairman Cranston. Now we will go to a few questions that I want to put to you. First, to you, John Sturdivant. I have had a long and productive relationship with your union. I look forward to working close with you now as you guide it. As I am sure you know, I am very concerned about the title 38 personnel system, and have been working for a number of years to make some improvements in that system.

The recent decision in the Colorado nurses case had a very significant impact on those efforts, and I want you to know that we are continuing to explore options to address the impact of that case. Indeed, Senator Murkowski and I will be proposing, when S. 2011 comes to the floor shortly, an amendment to preserve in fiscal year 1989 the status quo that existed before that case was decided. I don't have any question on that. I just wanted to cover that.

Mr. Sturdivant. Thank you, Mr. Chairman. We appreciate that. And for some reason it seems as though the VA has taken the position that those people who are responsible for patient care should not have some process to make sure that those working conditions are addressed. And when we have good working conditions we are going to have good patient care. A VA hospital is not an assembly line; you cannot shut it down when there is a problem. And certainly the process of collective bargaining, and talking to management and working out working conditions will result in better patient care. And we certainly appreciate your interest and your support in that area.

Chairman Cranston. Thank you very much,

Dr. Des Prez, on page 4 of your testimony you state that "All Chiefs of Medicine know of delays for cardiac catherizations and cardiac surgery that have resulted"—in what you term—"unacceptable outcomes." What is meant by that term, "unacceptable outcomes"?

Dr. Des Prez. Well if we send somebody out to wait for cardiac surgery, for instance, which does happen in many hospitals, there is the chance that they will have a myocardial infarction during that interim. I think that is a scenario that we all know has happened.

Chairman Cranston. Are there cases like that that have led to death?

Dr. Des Prez. I would assume, yes. I cannot bring it out of my own experience, but I assume yes.

Chairman Cranston. Thank you.

On page 6 of your testimony you state that "The RAM has introduced a subtle but real bias against these patients with complex illnesses." Could you give a couple of examples of such situations?

Dr. Des Prez. Well I can rather outline it generally. And I would like to have a minute to do so.

The RAM replaced a funding mechanism which I am sure you know was largely historical and to a certain extent political. And there were discrepancies in funding of hospitals, which seemed almost permanent in that what you got this year is what you had last year plus a little. And I think all of us in the field applauded the effort to have a work-related funding system, which the RAM represented.

And it also was keyed to produce increased efficiencies. And I think there is no question but that it did. But like all good things, it has an overshoot, and the overshoot in the RAM is encouragement to generate work-related units, or WWUs—pseudo dollars—doing those things that are efficient in a fiscal sense, and subtly but definitely tilting against those things which are very expensive in a fiscal sense. The same thing happened in the private sector. Whenever one gets a work-related type of thing, there is a great tendency to skim the profitable and the simple if you can and to tend to avoid the complex and the expensive.

I think that these are not things that I attach any blame to. I think they are part of the dialectic of running a big system, that you put in a corrective and that it does have a lot of corrective results. But it also will have some untoward results. And I would cite the tendency which is almost ineluctable for hospital administrators to seek out RAM favorable positions. If they do not, the other guy will. So it in a sense drives us past the point of efficiency and into what might be called sort of skimming circumstance. I mean, I have knowledge of a very nice nurse who now runs a foot clinic. Now I have known this lady for a long time. At least I have known of her for a long time. I don't think she ever was a foot specialist, but she is generating foot visits now. And it is that sort of tendency to increase RAM take, so to speak, that I think has pushed us past the pendulum of efficiency and good medicine and toward a certain degree of gaming the system so that the complex and the serious tend to lose.

As I say, I do not fault for a moment these efforts. I think they have been good. And I do not fault for a moment Central Office people. I am too old to curry favor. All right? And I have been in the job too long to worry about it.

I have always been a great admirer of the Central Office people with their initiatives and amazing responses to quick changes. I think we are in a transitional phase now and some other funding system needs to be seriously considered that will not drive us into gaming the system and competing for a fixed universe dollars with each other.

Chairman CRANSTON. Thank you very much.

Dr. Kiernan, what effect, if any, do you believe the current budgetary shortfall has on the VA's ability to recruit and retain qualified physicians and physician researchers?

Dr. KIERNAN. I think the shortfall, to one extent, will have effect on recruiting future physicians for our VA medical centers in that we will not have enough salary resources to put on adequate numbers of individuals to get the job done. That will lead to frustration. That will lead to fear of loss of quality of care. And as a result, physicians will leave for much more comfortable and more satisfying environments that we heard mentioned this morning.

We have a problem in the recruitment of VA physicians. We are not competitive with the private sector. We regularly, in Huntington, are losing physicians into our own community. I feel that something needs to be done about that.

Chairman CRANSTON. Thank you.

Miss Winslow, I thank you for your very compelling testimony and for your organization's ongoing close cooperations in many of these matters with the committee.

Ms. **WINSLOW**. Thank you, Mr. Chairman.

Chairman **CRANSTON**. I invite you to submit two further items for the record of this hearing if you would. First, your views on the Colorado nurses decision and how that matter might best be resolved as you see it. And, second, any additional information your organization has gathered on individual VA medical centers similar to that that you discussed with reference to Fargo.

Ms. **WINSLOW**. I would be delighted to provide both of those, Mr. Chairman.

Chairman **CRANSTON**. Thank you very much.

[Subsequently, Ms. Winslow furnished the information which appears on p. 457.]

Chairman **CRANSTON**. Let me finally ask, do any of you have any brief comments, simply following up on the testimony that was given to us by others on September 9?

Ms. **MCCARTE**. Senator, I would like to speak.

Chairman **CRANSTON**. Yes.

Ms. **MCCARTE**. In preparation for this meeting, I have talked to many VA nurses and presidents of unions around the country. Senator Murkowski talked earlier about nurses on the fast track in last week's meeting. That's not an exaggeration. Most of us wear tennis shoes to work in order to try to make ends meet. We are constantly prioritizing—that seems to be a favorite management word—frequently prioritizing, not just occasionally. We often have to leave duties for the next shift which puts them behind.

VA always has a larger patient per RN census than any other hospital in the community, in fact, almost always double. We constantly at our VA in Minneapolis have an acute shortage of intensive care nurses and also OR nurses, and this is the story across the country.

Nurses are constantly talked to about "nurse accountability." If you are a primary nurse you have to plan your patient's care from admission throughout their hospitalization. You are supposed to direct their teaching, their instructions about their medication, tell them about their tests, instruct their families. Some of these patients are only in for 2 or 3 or 4 days, and there is no way that this is humanly possible. You are supposed to with your nursing care plan try to instruct the other members of the health-care team to assist in this, but it is very difficult.

Current articles in nursing journals talk about nurse accountability. One of them that I read was entitled "Charting with the jury in mind. " Now this is really frightening when you work in an area where you are constantly cutting corners and wondering what is going to happen next.

In some of the areas I talked to there has been an increase in patient abuse charges, and several of those were because of short staffing. In one particular instance, it was the nursing assistant who was charged with patient abuse because the patient was not turned and fed in what the patient and the patient's family considered a timely manner.

This ward was already short-staffed. On this particular tour when the charge originated, another staff member had been "floated" to another area to cover sick leave, so they were already doubly short. Management proceeded with the patient abuse charges against the staff member instead of taking some of the accountability for the shortages.

It puts workers in a double bind. And you feel that you are not able to give your best service to your patients, plus you are really being intimidated by management.

The turnover rates are fantastic. It is estimated that it cost $1,200 to orient a new RN to a hospital. A large number of the RNs that we are currently orienting at the VA medical center in Minneapolis leave within 9 to 12 months for more profitable employment and less stress in outside hospitals and the community.

It is estimated that it cost $8,000 to $12,000 to orient a nurse to an intensive care setting, and there is a constant shortage. There is head-hunting taking place in communities for intensive care nurses offering fantastic bonuses and benefits to nurses if they will work in their hospitals.

I talked to a nurse in Sepulveda VAMC, California, Senator Cranston. They have a 30-bed ward. This ward was a step down telemetry ward, plus on this same unit they had two patients on respirators. The usual staff on this ward was two RNs and two other staff members, sometimes LPNs, sometimes nursing assistants. The telemetry patients have alarms that go off. The respirator patients have alarms that go off. The signal lights have bells that ring. And you have four people trying to take care of 30, in many cases, intensely ill patients. Ordinarily respirator patients are taken care of in intensive care units, it is quite unusual for them to be on a ward. The stress is very difficult to describe and very intense. And the turnover, as I said, is incredible. The revolving door syndrome is really high.

Another thing that we have just found out is that apparently nurse anesthetists may now charge, and direct bill for Medicare. This is really going to affect nurse anesthetists within the VA if they can go to a private hospital and direct bill as well as have a stable salary.

I guess that is everything. I just wanted to try to express the concern that I have as a 29-year veteran with the VA Nursing Service, that we really need help. Thank you.

Chairman CRANSTON. Thank you very much. I know that is very heartfelt and it was very informative and I thank you for it.

Do any others of you have any comments based on the former hearing?

Ms. MORRISSEY. Mr. Chairman, as we stated earlier today, NOVA is speaking for the nurses who continue to stay and care for the veteran patients in spite of all the difficulties described above. We are loyal and dedicated employees who pull together in difficult times and who like taking pride in what we do and dislike seeing the VA attacked and criticized from without. We are resentful when non-VA nursing colleagues indicate they think the VA is a second class place to work, or assume that if you cannot work elsewhere you can always work at the VA. We have glimpses from time to time of how great the VA health-care system can be, and we take pride in the system's accomplishments. We do have a worthy mission, Mr, Chairman, but we do need the resources to fulfill that mission.

Chairman **Cranston**. Thank you.

Bob, do you have any statement or questions?

Senator **Graham**. Mr. Chairman, first, I would like to commend you for what has been a very illuminating set of hearings. And I know this will be a continuing interest of this committee and of yourself.

I would like to ask some questions in a somewhat different area than has been pursued at our previous hearing and the portion of today's hearing that I have participated in.

I am interested in the question of the equality of health-care services from community to community in this country. What would be the standards that you would look to evaluate the level of equal access to equal medical services by veterans from community to community in the country? What would be the standards that would indicate an equivalent level of services?

Dr. **Des Prez**. I am not sure I am qualified to answer this, but the usual thing, of course, is community comparability. That is the standard that the courts use. It is difficult, however, from my point of view—and I have been with it a long time—to have the VA system pushed into the circumstance of mirroring the private sector in too many ways. I would like to disassociate ourselves from that to a certain degree.

Over the years, the VA in many circumstances has been the best place to be for a professional. It has been the place where doctoring was more fun to do, more gratifying to do.

I think that all of us within the system know what we are called to do, and mostly over the years we have pretty well done it. We have been led to do it and we have done it. What we have now is really quite exceptional circumstance, a convergence of forces, which we have to solve in a monetary way or, hopefully—rather, I hope not—but in a trimming of mission way. But this is not a usual circumstance. This hearing would not have been necessary over the years.

And as I say, I do not think we should be looked at as a mirror in the private sector. We are better than the private sector in many important ways. That is why we have I system that is better than the private sector.

Senator **Graham**. If I could, let me sharpen the question and also to prove my colloquialism in asking it. I come from the State of Florida. I have met with a number of representatives of the Veterans' Administration medical services and representatives of veterans' organizations who have expressed the feeling that, in large part because of the rapid increase to the veteran population in my State and the failure of resources from the Veterans' Administration to parallel that increase in demand that there has developed a differential in medical services.

My question to you as professionals is how would you go about either answering that in a way that would indicate that that differential in services is not reality, or what evidence would you accept as being sufficient to justify the claim of discrimination?

Dr. **Kiernan**. May I make a few comments?

Senator **Graham**. Yes, sir.

Dr. **Kiernan**. I think there are several standards that I would look at to try to compare access to care for veterans versus access to care by the private citizens of the community hospitals.

Senator **Graham**. But that is not the issue.

Dr. **Kiernan**. That is not the issue?

Senator **Graham**. The issue is not access between veterans in the general population, or the nonveteran population. It is the question within the veteran population. Is there equality of access to veterans' medical services in Tampa as in Topeka, KS?

Dr. **Kiernan**. How would you compare? How would you measure that?

Senator **Graham**. How would you measure if one of the goals of the Veterans' Administration is to provide the same level of access to care on a nationwide basis? What would you, use as your gauges to determine whether that objective was being fulfilled?

Dr. **Kiernan**. All right. I can answer that.

I have five items here. One, is there ready access; in this sense that can the veteran come from all reaches of the primary service area and receive care just as readily as any other veteran? In the cases where a veterans' hospital may be in the far reaches of a mountain or a desert, are there appropriate outreach services that would provide that care nearby the veteran's home?

Two, do the hospitals have the comprehensive and competent care at every center versus another? That can be pretty much measured by quality assurance monitors, I believe.

Three, is the care timely? When patients are ill, do they get care right away?

Four, is there proper followup? And is there time allotted during those followup examinations to fully comprehend the needs of the patient and give proper treatment?

Five, is there proper preventive care that is provided at all medical centers? Those are the five items, sir.

Mr. **Sturdivant**. Senator, I guess where I see that is I think if you start from a basic premise—and I have been all over this country, and I have spent a lot of time in Veterans' Administration hospitals, and not just on the day shift when they have the tours, but in the evenings and on the midnight—and one of the things that I have noticed and validated from the people that I talked to is the Veterans' Administration is seriously undercapitalized in human resources.

Human resources—we talk about our institutional resources and we talk about financial resources—to get a job done. Then the other resource that we need, and Government utilizes, are human resources; it's people. And the Veterans' Administration—and I think you have heard the testimony—the Veterans' Administration is seriously undercapitalized in human resources. If you take that basic premise, and you go to the point that if all of the hospitals that I have seen—and I have checked this with my colleagues—just about all of the hospitals that I have come in contact with we visited are understaffed, seriously understaffed. If we go to your State where there are more veterans, and those veterans, if there are more veterans in a system, and more of those veterans gravitate to a place that is understaffed, as a majority of the system is, then I would say that those people in your State are going to receive less care. They are, once again, going to be in a situation, as Mary McCarte indicated, that the crisis management is higher, because you have got more veterans and everyone is understaffed.

We need to deal with the question of getting enough staff and the proper type of staff that are properly paid, and with the right kind of working conditions, a stable work force. And we have got to do that and strengthen our human resources so we can provide the care for veterans regardless of whether they are in Florida or in Kansas.

When they went out to fight for our country I don't think anybody asked them what State they were from. And then certainly that does not take into consideration when you are in combat and it should not be a consideration of the type of care they receive.

Senator GRAHAM. Are there any other additions to the question or to the response to the question of how would you evaluate the degree to which the Veterans' Administration is meeting the standard of equal access to its medical services from community to community across the Nation?

[No response.]

Senator GRAHAM. Let me turn to a second issue. I have been participating in some programs recently on the question of health status, how the health of Americans can be enhanced by a greater emphasis on the maintenance of good health through personal habits, through effective periodic screening, other devices that attempt to identify an early stage condition which, if left unattended, can become a serious health problem.

To what degree does the Veterans' Administration assist the veteran in the maintenance of their status of good health?

Ms. MCCARTE. Frequently when the patients come to the outpatient clinic one of the primary duties of the nurses in outpatient clinics is to instruct the patient in their care, the use of their medication, side effects to watch for and this type thing. And also when they do make their clinic visits there are some routine things that are done; for instance, chest x-rays, blood work and this type thing.

I guess from the nursing and the nursing service point of view, our main responsibility is trying to teach the patient and his family how to maintain or to maybe better their health status.

Senator GRAHAM. And other comments on that question? Yes, sir.

Dr. KIERNAN. The VA does have a program in preventive health care. It has been popularized over the past several years. Physicians by their nature are moved to provide better health care for their patients. Then again, it was only formalized a couple of years ago within the VA.

The program is a large one and requires a fair amount of time and involvement of resources. And I would imagine that the whole scope of preventive health-care measures carried out in any one individual medical center may differ from another.

Indeed it is important. We all recognize that. And we continue to try to move to provide as much care as we can.

Senator GRAHAM. Any other comments?

Dr. SCHAFER. Senator Graham, the question you asked obviously is going to be part of the national debate that will occur over the next few years as to just where we go with this whole problem of health care in our society. And I think in that debate—and I mentioned this in my remarks just a little bit ago—there are so many very, very attractive features of the veterans' medical program that have got to be brought to the forefront of that discussion. And the area about which you inquire is certainly an area where I don't think the veterans' medical program has to take second place to anything that exists in the private sector.

We have so many features of the veterans' medical program that are part of the answer to your question. But to single out just one of them, we have something called patient education, a formal structure within the program, and in each facility we have committees charged with assessing what is going on, what might better go on. And this is interwoven into every little facet of the interface of our professional people with the veteran patients.

Let me just give you one little example and then I shall cease and desist.

We had a dental technician by the name of Ilene at our local hospital, and Ilene was concerned about good oral health, particularly dental and gingival health. And she took it upon herself to equip a little rolling cart with a few instruments, a few materials, and a simple monocular microscope, and she would wheel this cart around to our different wards and rooms. And, of course, the patients were very curious about, well, you know, what is she about? And she would tell them. She would say, come over here and let me get a swab off of one of your front teeth. And she would take a little swab, and then she would put it on a microscopic glass slide, slide it under the microscope and invite the patient to look and see what was going on. Well, he saw, all of these little squiggly things, and, my goodness, they were running all over each other. And she said, now let me show you what can happen to your teeth and to your gums. And she went through a dental routine, a very simple hygienic routine, did another swab, and, my goodness, there were almost no little squigglers there.

She built up a practice in our hospital that I think benefitted our patients enormously. As a matter of fact, Ilene became sort of a walking monument, if you will, because patients were coming back to the hospital to have her take the swab to see how well they were doing and whether there were still little squigglers.

Senator **GRAHAM**. Has any analysis to your knowledge been done attempting to compare the health status of the veterans population to a comparable group of Americans in terms of age, other external circumstances? For instance, on issues such as alcoholism, heart disease, weight, hypertension, conditions that are subject to either control by patterns of life style or are subject to remediation by early identification and intervention? What is the health status of America's veteran population as compared to a similar general population that exists?

Dr. **DES PREZ**. I don't know that any good cross sectional, surveys have been done. The people we take care of are ill people. There is no question about that. And they have a variety of——

Senator **GRAHAM**. The people that get to you are ill or they would not be with you.

Dr. **DES PREZ**. Right.

Senator **Graham**. But I am talking about, what is the Veterans' Administration's responsibility to the health of the veteran population generically as distinct from its responsibility to that component of the veteran population who gets ill enough to require professional, generally institutional, care?

Dr. **Des Prez**. Well I hear where you are going and I do not know exactly how to respond to that, except to say that in a universe of fixed dollars I think that doctors and hospitals are going to always respond to individuals who are sick at that time. And also the sort of thing that you are reflecting contains a lot of assumptions that have yet really to be rigorously demonstrated. I mean, the degree to which lifestyles can really factually be altered needs to be demonstrated. I know there is a great deal of enthusiasm for it now, but I don't know if there is any rigorous demonstration.

It is awfully easy to go pretty far over in this direction because of the emphasis on this in the private sector. However, I am not sure that it—we will do as much as we can. We have good staff, good clinics in hypertension many diabetic centers and things like that, things that we know we have got our hands on. I don 't know that we can change the lifestyle of the younger veteran without an entirely different type of apparatus. I am not sure that it would be one that I would like to get into.

Senator **Graham**. Any other comments on that question? Yes.

Dr. **Kiernan**. I am not aware of any study that has been done comparing the health status of American veterans versus the general population, but it may be of interest to you in the State of West Virginia, the Department of Health did a very large epidemiological study where they studied years of productive life lost by West Virginian adults. That study was very revealing. It showed that in certain counties of the State the incidence of coronary heart disease and loss of life from that, premature loss of life and the incidence of lung cancer was great. The study gave the State an opportunity to focus on those special medical areas.

Senator **Graham**. Mr. Chairman, I appreciate this opportunity to pursue these areas. I have some questions that I had intended to ask of Mr. Turnage at our previous meeting and I was unable to do so. I would like to ask permission to submit those in written form.

Chairman **Cranston**. Absolutely, yes.

Senator **Graham**. Thank you.

Chairman **Cranston**. I am delighted that you are focusing on preventive health care. I think that is a very important field. Awhile back there wasn't any provided by the VA. And in 1979 we began to explore that and wrote into the law a provision that they have the people come in to the VA with their health problems. So I think we should explore what more should be done in this front. I appreciate your interest.

I am going to have to leave in a moment, and let me explain one thing we are now going to have to do. I am going to ask Jon Steinberg, the Committee Chief Counsel, to ask Dr, Winship some questions about the information in Dr. Gronvall's letter to me of yesterday. That was a letter responding to my request at the September 9 hearing for a breakdown of the $608.75 million fiscal year 1989 funding shortfall estimated by DM&S. So at this point I thank the panel very much for your presence. You have been very helpful and I appreciate and look forward to working with you.

I will now ask Dr. Winship to come forward. And I will administer the oath before I leave.

TESTIMONY OF DR. DANIEL H. WINSHIP, ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION, ACCOMPANIED BY ROBERT P. DUNN, ASSISTANT DIRECTOR, BUDGET FORMULATION

Dr. WINSHIP. Mr. Chairman, I would like to request that Mr. Bob Dunn, who is accompanying me here from our Resources Office, join me at the table.

Chairman CRANSTON. Fine.

Dr. WINSHIP. I think he would have a better answer to some of the details.

[Whereupon, the two witnesses were duly sworn.]

Chairman CRANSTON. Thank you very much. Jon Steinberg, the committee's chief counsel, will take over.

Mr. STEINBERG. Thank you, Mr. Chairman.

Dr. Winship, you have a copy I believe of the September 19 letter to Senator Cranston from the Chief Medical Director.

Dr. WINSHIP. Yes, I do.

Mr. STEINBERG. The attachment to that sets forth details of the breakdown of the $608 million, which actually turns out to be $608.754 million I believe.

Dr. WINSHIP. Yes.

Mr. STEINBERG. And it breaks it down in approximately nine categories. And I would like to run down those categories with you for a moment and see if we can get a clarification of a few items.

The first item is a $98.411 million shortfall under the heading of "Productivity." And it says, "This level reflects shortfall generated by the prospective productivity improvements for 1988 and 1989 that have not been withdrawn on a recurring basis from the VAMCs." Two questions about that.

You say that the dollars have not been withdrawn on a recurring basis. If the productivity increment was assumed in the budget let us say for 1988, as it was, why have the dollars not been withdrawn?

Dr. WINSHIP. I believe those dollars have been generated primarily from reallocations within the accounts in Central Office rather than being taken from the target allowance.

I would like to have Mr. Dunn comment on that as well, please.

Mr. DUNN. Since these are operational shortfalls, and we have not yet started operating in 1989, they would have to be taken from the facilities in the operating plan development.

Mr. STEINBERG. But the budget is premised on the notion that there will be an increase in productivity which will make up for this reduction in funding. Is it your testimony that for fiscal year 1988, for example, no such 1 percent productivity increase has been realized?

Mr. DUNN. The FTEE that normally is associated with the productivity comes back to the system basically by realignment to activators. Activations of new facilities require new people as well as dollars. The productivity reductions are based on a percentage which equates to a dollar figure, but it is basically a reduction in personnel. In 1989 we did receive support for activations by realigning these dollars.

Mr. **Steinberg**. Then expressed in another way, if the dollars that were earmarked in the budget for new activations were not there but rather were carried in the base, then no productivity increase would have been anticipated by the budget. Is that correct?

Mr. **Dunn**. Basically that is true. What we are saying is that the productivity anticipated is spent for something else up front.

Mr. **Steinberg**. And in this case it is to support staffing, principally.

Mr. **Dunn**. Yes. For activations primarily.

Dr. **Winship**. Let me clarify about fiscal year 1988, Mr. Steinberg.

Early in fiscal year 1988 we withdrew FTEE commensurate with the amount of money that would be represented by the productivity. We did not at that time withdraw from the field dollars that went along with employment. Later in the year, we withdrew some of the funds from the field, but we made up the rest of the funds by reducing other Central Office accounts. So overall, in the Agency that would result in a realignment which would have made up the productivity reduction.

As far as the medical centers were concerned, in fiscal year 1988 they did not have to make up those dollars through an individual line item called productivity reduction.

Mr. **Steinberg**. And is the $98.411 million composed of both 1989 and 1988 money?

Dr. **Winship**. Yes, that is correct.

Mr. **Steinberg**. Do you have a breakdown?

Mr. **Dunn**. About $33 million in 1988, the balance is 1989.

Mr. **Steinberg**. And why is the $33 million that is 1988 pertinent in 1989?

Mr. **Dunn**. Productivity is a recurring phenomena. If the money are not withdrawn from the recurring requirements at the facilities you are required to find it in your next operating year, either from a nonrecurring source or a recurring source.

Mr. **Steinberg**. Thank you.

Let 's go to the next item. And, Al, I believe you have a copy of this letter.

Mr. **Ptak**. Yes, I do.

Mr. **Steinberg**. $11.050 million for imposed savings. It says "These reductions have to be withdrawn from field operating accounts." This refers only to 1989. There is no reference to 1988 here.

Why in the budgeting for fiscal year 1989 have those so-called savings, which you call "imposed savings," not been taken into account in budgeting to the medical centers?

Mr. **Dunn**. we have to keep in mind that this is an operational document. While the budget did reflect those reductions, they have yet to be assigned in the field. So until they are, it is something that has to be reckoned with.

Mr. **Steinberg**. What does the word "imposed" mean?

Mr. **Dunn**. It means these reductions are the result of things that have occurred in the system, such as standardization of supply items, and application of DHCP. Those are the two main pieces of that $11 million. It does not mean it is inappropriate. It just means we have not yet assigned the reductions. And until we do, we have an operational consideration.

Mr. **Steinberg**. You have not yet found the savings attributed to these matters yet. Is that your testimony?

Mr. **Dunn**. The source of them, yes. That takes place when the operating budget is put together.

Mr. **Steinberg**. All right.

Going to the next item on contract hospital, where you show a shortfall of $47.207 million, do you know what amount is included in the 1989 budget for contract hospital care?

Mr. **Dunn**. I would have to supply it for the record.

Mr. **Steinberg**. All right. If you would do that.

[Subsequently, the Veterans' Administration furnished the following information:]

The 1989 budget includes $142,607,000 for contract hospital care. A total of $137,953,000 is for per diem payments for the provision of direct medical care and $4,654,000 is required for administrative support of the program.

Mr. **Steinberg**. Next, we have the homeless programs, $23.619 million. And I have no questions with respect to that item. We seem to understand that quite clearly.

The next item is special pay, where it shows $97.208 million, which is over and above any amounts appropriated for such purpose. And you reference $30 million appropriated for 1988 with respect to special pay, and, of course, $45 million just appropriated for 1989.

Why, in estimating the fiscal year 1989 shortfall, do you take into account a 1988 appropriation for special pay?

Mr. **Dunn**. Because the level of special pay is the total level that we anticipate requiring in 1989.

Mr. **Steinberg**. So, in other words, it is part of a base on which a 1989 figure has been built?

Mr. **Dunn**. Right.

Mr. **Steinberg**. All right.

Now the next item is AIDS, $19.130 million. And you describe that as a combination of the cost of the AIDS provisions in public Law 100-322 and the shortfall that is going to result from the direction of the Appropriations Committees to freeze the budgets of the facilities that are principally impacted by AIDS treatment. And I take it that there you are referring to the requirements to maintain FTE at those facilities?

Mr. **Dunn**. At the 16, yes.

Mr. **Steinberg**. Right.

What is the breakdown as to the $19.130 million between those two subcategories?

Mr. **Dunn**. Approximately $12 million and $7.130 million.

Mr. **Steinberg**. $12 million is for Public Law 100-322?

Mr. **Dunn**. $12 million would be for the AIDS impacted facilities.

Mr. **Steinberg**. So that $7.130 million is the same $7.130 million that appears in footnote 1 at the bottom of the page.

Mr. DUNN. Right.

Mr. STEINBERG. So since you have added it in there, you would be subtracting it from Public Law 100-322.

Mr. DUNN. As part of the reconciliation between the $117 million and the $106 million.

Mr. STEINBERG. All right. So it could have been carried either way. It could have been carried as part of Public Law 100-322 and then the $19.130 million would be reduced to just the $12 million.

Mr. DUNN. Right.

Mr. STEINBERG. It seems to us that it clearly is attributable to the enactment of that public law and so, for purposes of explaining the shortfall, it would have been clearer to us, at least, if you had carried it in Public Law 100-322 category, the last category, and not in that category. But I think we understand it.

Now, that $19.130 million does not include the cost of implementing the universal precautions which, in response to a prehearing question that we received on the 8th of September, you indicated was $25.8 million. Why is there no inclusion in this overall shortfall estimate of those costs for implementing the universal precautions?

Dr. WINSHIP. Let me comment on that.

I believe that in the development of this particular document that we have before us, it fell through the cracks. I think that was an oversight. I think we easily could have put it in here. And in fact, in further development of the anticipated shortfall, as Senator Cranston mentioned in his opening statement that we discussed at the meeting, it is considered. But it is not contained here.

Mr. STEINBERG. Those other items, as I understand them, are shortfalls resulting from reallocations of resources in the base.

Dr. WINSHIP. In the main, yes.

Mr. STEINBERG. Right. And that figure was approximately $440 million. You are not suggesting the $25.8 million is included in that figure, are you? Because that is the prospective figure. You have not implemented universal precautions at this time.

Dr. WINSHIP. No, we have not implemented them. And I don't think it is in that figure. However, I think it would be in a more accurate estimate of the shortfall.

Another factor is that the actual report of the CDC detailing exactly what the universal precautions are is very recent. And in developing the estimate, even though we had some preliminary numbers, we did not have the final report. I think that it is finalized. We could certainly add it on here because it is not contained in this number.

Mr. STEINBERG. So it would be fair then to say that we are talking about $634.553 million, if I did my math correctly, rather than $608 million.

Dr. WINSHIP. If we have that component, yes.

Mr. STEINBERG. And there is no question that the system has to comply with those precautions that is being mandated under the Occupational Safety and Health Act. The system is going to have to do that.

Dr. WINSHIP. That is correct.

Mr. STEINBERG. So it would seem that that is at least as much of a clear shortfall as the other categories. Could you, if you do not disagree with that, provide us for the record with a correct chart showing that item in here, please? And if there are any other last minute type of items—there seems to be the implication in what you said that there were that have not been taken into account in the $608 million—we would appreciate your so indicating in the revised chart that I just requested.

Dr. WINSHIP. Yes, we will do that.

Mr. STEINBERG. Thank you.

[Subsequently, the Veterans' Administration furnished the following information:]

MEDICAL CARE DETAIL OF ESTIMATED "SHORTFALL"

The Department of Medicine and Surgery currently estimates the operating 1989 "Shortfall", including universal precautions and discretionary provisions of PL 100-322, to be $634,563,000. The following chart summarizes the categories contributing to this deficiency:

[In thousands of dollars]

Category	*Amount*
Productivity: This level reflects shortfall generated by the prospective productivity improvements for 1988 and 1989 that have not been withdrawn on a recurring basis from the VAMCs	98,411
Imposed savings: The budget contains projected savings for Supply improvements, the DHCP program, and CALM improvements. These reductions have to be withdrawn from field operating accounts	11,050
Contract hospital: This is the current estimate of need less the funding level in the 1989 appropriation	47,207
Homeless programs: This represents the shortfall resulting from the required funding of both the Homeless Domiciliary program and the Homeless Chronically Mentally Ill program. Appropriated dollars expire in 1988 and funds to operate these programs must come from realignment of VAMC resources	23,619
Special pay: Estimate of need accumulated since the end of 1987 less the amounts appropriated in fiscal year 1988 ($40 million) and fiscal year 1989 ($45 million)	97,208
AIDS: Reflects the effect of "freezing" the budgets of those facilities identified for special AIDS support in the 1989 Appropriations Act	12,000
Payroll: This is the unfunded costs of within-grade increases and announced increases in the Federal Employee Health Benefits Program	120,029
Pay raise: This is the amount needed to fully fund the 4.1 percent pay raise in January 1989	86,065
Public Law 100-322: Funds necessary for the following provisions of this new law—State Home Per Diems, Tuition Reimbursement, information and training on AIDS prevention, revised Outpatient Eligibility, Health Care Outside the US, POW Dental Care, Beneficiary Travel, Saturday Premium Pay, Standardization of Medical Supply items, and a Report on Contract care	[1] 113,164
Subtotal	608,753
Universal precautions: Estimated cost of universal precautions as recommended by the Centers for Disease Control as necessary due to the AIDS epidemic	25,810
Total	634,563

[1] Differs from the $117,204 estimate of cost of mandatory provisions of law by the following: −$4,700 for Readjustment Counseling which is considered to be in the 1989 appropriation and −$660 for Health Care Outside the US not initially considered mandatory—$117,204 minus $4,700 plus $660 equals $113,164.

Mr. STEINBERG. Under the next item, payroll, $120.029 million, you refer to two subcategories with in-grade increases and the Federal employees health benefits increases. Could you break that down for us?

Mr. **Dunn**. The employee health benefits would be approximately $61 million and the balance would be within grades.

Mr. **Steinberg**. All right. Thank you.

And just to go over your reasoning with respect to the final item, we have no questions on the pay raise item of $86.065 million; that is quite clear. The last item is $106.034 million, which is a reduction from a figure previously given to the committee of $117.204 million for implementation of Public Law 100-322.

First, I believe in our discussion about the AIDS money we have clarified that the $7.130 million reduction shown there for AIDS could well have been included here and not included under the prior AIDS category. I would appreciate it if you would reevaluate how that should be categorized, and would consider, when you revise this chart, perhaps of reducing the $19.130 million down to $12 million, and including the $7.130 million in Public Law 100-322 figure because it is clearly a function of the enactment of that law.

Now you also show there a reduction of $4.7 million in readjustment counseling. I will try to explain what we think that means and will you tell us if this is the correct understanding: that since that law required that the Agency not close any existing vet centers without giving prior notification to the Congress, and then waiting 120 days thereafter, and since you have not notified the Congress of any intent to close vet centers, you consider those two events—that is, the enactment of the notice and wait provision—and your decision not to notify us with respect to any closings, to add up to a statutory requirement to maintain the level of funding from fiscal year 1988, that is not to make the reduction proposed in the 1989 budget of $4.7 million. Is that how you get to the conclusion that there is a readjustment counseling mandate in Public Law 100-322?

Mr. **Dunn**. The appropriation bill, Public Law 100-404, directed us to support the readjustment counseling program from within the dollars provided. Therefore, the need established with Public Law 100-322 is not there since it was taken care of with the appropriation.

Mr. **Steinberg**. Right, we followed the tradeoff clearly. I just wanted to review your analysis. And I would think it would be helpful if you would provide for the record a statement from the general counsel as to reaching the conclusion that there is a mandatory funding impact on the readjustment counseling program from the enactment of Public Law 100-322. It is not self-evident to us that that is such an impact. It seems to us that the matter under the law was entrusted to the discretion of the Administrator with, of course, the notice-and-wait requirement. You are absolutely correct that the appropriations bill certainly subsequently appropriated the $4.7 million as part of the base funding for the 194,140 FTE that has been carried for 5 fiscal years. So if you would get us further clarification of that, we would appreciate it.

[Subsequently, the Veterans' Administration furnished the following information:]

We have consulted informally with the Office of General Counsel regarding your questions and conclude that there was not necessarily a legal mandate to restore funds to the Readjustment Counseling program in fiscal year 1989 as a result of passage of Public Law 100-322. However, we continue to feel that the enactment of

Public Law 100-322 created an operational necessity to restore funding to the program in fiscal year 1989.

Mr. STEINBERG. I have no further questions with respect to any of these items on this page. I would like to ask both of you if you are aware at this point of the status of the VA's request for supplemental funding for 1989 which Senator Cranston referred to in his opening remarks?

Dr. WINSHIP. Yes. I can comment. I know that General Turnage personally met with Mr. Miller from OMB yesterday. I do not know the outcome of that meeting, but he is proceeding forward, as discussed last week.

Mr. STEINBERG. If you could get us an update on the results of that meeting as soon as possible we would greatly appreciate it.

[Subsequently, the Veterans' Administration furnished the following information:]

As mentioned above Administrator Turnage has met personally with Mr. Miller at the Office of Management and Budget to bring him up to date on needs of the Medical Care Account in fiscal year 1989. This funding situation is a matter of utmost concern to the Administrator. He has submitted a supplemental fiscal year 1989 funding request which is now under consideration.

Mr. STEINBERG. Al, do you have any questions that you would like to ask on this document or perhaps on anything pertaining to the hearing today?

Mr. PTAK. Thanks, Jon. We have some questions for the witnesses. Senator Murkowski would like to have those submitted.

Mr. STEINBERG. Fine.

Dr. Winship, if we could ask you to just remain at the witness table for a moment. We may have another Senator on the way here and we didn't want to adjourn and not give him an opportunity to be present. So we are checking on that, and if you would just bear with us for a moment we would appreciate that.

Dr. WINSHIP. Sure.

Mr. STEINBERG. Senator Specter, would you like to sit up here? You are most welcome to,

Senator SPECTER. I am fine. Thank you, Jon.

Mr. STEINBERG. Senator Specter, we have before us, although they were not scheduled on the witness list, the Associate Deputy Chief Medical Director, Dr. Daniel Winship, and Mr. Robert Dunn, with the Controller's Office. That is correct, isn't it?

Mr. DUNN. DM&S.

Mr. STEINBERG. DM&S Budget Resources. And we had just followed up with them, as Senator Cranston had asked me to do before he left, on a breakdown of the shortfall which they provided to us yesterday. We just were going over those categories, and we have concluded. So it is entirely in your court at this point, Senator.

Senator SPECTER. I haven't heard the direct testimony, so I don't think I will do any cross examination at this point, Jon.

Mr. STEINBERG. There is no further testimony.

Senator SPECTER. Oh. I see.

Mr. STEINBERG. So if you have some questions at this point for the VA——

Senator **Specter**. No. I do not. Thank you very much. I had other commitments and could not be here. I will review the proceedings and let you know.

Mr. **Steinberg**. I might just note, Senator, for your information at one point that we did clarify some things on this document and the VA is going to submit a revision of it. One is that it does not include $25.8 million which the VA told us on September 8 was necessary to implement the universal precautions with respect to infectious diseases. I think you are familiar with that. As you know, OSHA has required that all hospitals in the United States comply with those universal precautions. And so this figure of $608.7 million should actually be at least $634.553 million. And the VA is going to submit a revision of this and we will, of course, circulate that to all members.

Dr. **Winship**. We will be happy to answer any further questions you have that you want to submit to us.

Mr. **Steinberg**. Thank you, Dr. Winship. We will get those to you as promptly as possible. We appreciate your presence here today, and we thank the Administrator and Dr. Gronvall for making that possible. If you could get that response back to us as soon as possible we would appreciate it.

Dr. **Winship**. Yes, we will.

Mr. **Steinberg**. Both of those responses, please. Thank you.

This hearing is adjourned.

[Whereupon, at 10:43 a.m., the hearing was concluded.]

APPENDIX

Statement

SENATOR ALAN K. SIMPSON

Health Care Oversight Hearing

Mr. Chairman, I look forward to reviewing the testimony to be presented here today. It is most appropriate that this committee exercise its oversight function to review the delivery of medical care to this nation's veterans.

It is also appropriate that we bear in mind the fiscal constraints and reality facing not only this committee, but the entire Congress, and the entire nation. I would suggest that this committee, and our counterpart in the House, might do well to scrutinize our own actions in mandating programmatic changes and creating new entitlements -- for which there is no money in the federal budget -- leaving VA medical centers to pay for more services with the same amount of money.

In just this past year, Congress has removed from the VA the flexibility to deal with beneficiary travel payments, but provided no funding to specifically pay for the benefit. We did this in spite of the fact that the VA assured us that no veteran who was otherwise unable to reach a VA medical center would be denied travel assistance of some sort, and in spite of the fact that veterans' service organizations were developing volunteer networks and providing vans to provide additional assistance to needy veterans.

We have also created an entitlement to outpatient care for service-connected veterans. We have added to the list of diseases that are presumptively service-connected, eliminating entirely any need to show connection with service for 13 additional diseases.

These actions on our part may strain the resources of the VA and its medical centers. If we are unable to provide the additional funds to carry out these services -- and we are constrained by bipartisan budget agreements and the extent of the federal treasury -- we do a disservice to the people in the field who are trying to deliver the best health care possible to our veterans.

Let's just review the figures here and cast a little light on the discussion. The federal budget for FY 1989 is $1.1 trillion. The VA is allocated $28 billion. Our deficit is $146 billion, and our debt is $2.56 trillion. Just think about that for a minute. We will spend $146 billion more than we take in this year.

Every aspect of this society receives the benefits of these expenditures in some fashion or another, and every segment of society must do its part to pay for the benefits. We in Congress, for our part, must ask ourselves serious questions when we prepare to mandate new programs and new entitlements. The most serious questions should be

1) is it necessary to require this program, rather than to leave it up to the discretion of the agency charged with administering the benefit? and

2) where is the money to pay for the program going to come from?

These are not questions we can afford to ignore.

I hope we hear a few words today addressing those points. The federal budget is not a bottomless "pot of gold." It is limited, and the programs we authorize and mandate should be those which are absolutely necessary and for which adequate funding is available.

CHIEF MEDICAL DIRECTOR'S TASK FORCE REPORT

on

FISCAL YEAR 1989 BUDGET

FINAL REPORT

Veterans Administration

August 4, 1988

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EXECUTIVE SUMMARY

This report presents 18 options to offset VACO-projected deficits for FY 1989. If all were adopted, these options would recover $787 million. Actions previously approved in the FY 1989 Target Allowance and prior-year actions to set aside funds for contract hospitalization and internal special pay needs amount to $336 million. The two amounts can be used to meet the $819 million shortfall. The options are a collection of actions and recommendations presented by VACO elements including those collected via field-level input through the Regional Budget Hearings, and those proposed by the CMD's Field Advisory Committee. A list of options considered by the Task Force to minimize the FY 1989 operational shortfalls is contained in Attachment A. The recommended budget options proposed by this Task Force including the associated savings are listed in Attachment B.

A major recommendation made in association with workload reductions represents the initial step in moving the system toward access parity by adjusting workloads and funding in accordance with entitlement and eligibility. In addition, the Task Force recommends suspension of the Resource Allocation Model as a resource-distribution tool for FY 1990 and FY 1991.

The Task Force members unanimously agreed that absorption or recovery of the resource shortfall is in direct conflict with the assumption that employment be maintained at the level of 194,140 FTEE. Therefore, many of the options in this report deal with FTEE reductions to prevent further erosion of operating flexibility in all other accounts. This report recommends a reduction of 3,178 FTEE in meeting the projected shortfall if all actions are exercised and successful. At the other extreme, 11,127 FTEE would need to be reduced if no options are enacted and all aspects of PL 100-322 are implemented.

Considerable discussion centered around the actual size of the budget shortfall. The Task Force believes $819 million is a good, working estimate of the magnitude of the problem for FY 1989, nevertheless this figure does not recognize the recurring shortfalls existing at VA Medical Centers caused by absorptions and reductions in previous fiscal years without a corresponding reduction in workload expectations or assigned FTEE. The Task Force believes that the true magnitude should be documented for the use of the CMD in addressing FY 1989 and future resource requirements. Toward this end, the Task Force has provided a data-gathering format to be reviewed by the Regional Financial Managers and to be used for a follow-up report. This report will be available in the near future.

Also, provided is a long-term strategy outlining several actions the Task Force believes should be used to address shortfalls beyond FY 1989. The emphasis in this section comes from the realization that much of what is proposed in this report is really a stop-gap measure that cannot be used to address the recurring needs of the Department over time.

The Task Force appreciates the opportunity to provide input into this matter.

LONG-RANGE STRATEGIES

A sound and well-designed long-range strategy is essential to the VA as the Department anticipates fiscal shortfalls in future years. The strategy must include dramatic measures that address service demands and reduced funding levels in outlying years.

Some of these dramatic measures include closure of medical centers or consolidations to provide allowable levels of care while redistributing funds. In formulating these strategies, we recognize that there are organizational and process impediments to securing adequate resources to meet the demands upon us.

Each issue will require exploration and development by special panels or ad hoc groups.

1. *Mission Changes* - The simple issue of "how we do business," or the more complex problem of hospital closures, needs to be explored. Issues identified throughout the report affect the Department of Medicine and Surgery and individual medical center missions as follows:

a. *Department*

- Clinical - The challenge to provide quality medical care is becoming more formidable each passing year as the resource base is being eroded for various unfunded programs and new mandates. The Department must maintain a comprehensive health care delivery system that is competitive with and in full compliance with accepted standards of care in the community while responding to the needs of our identified veteran population. This will require a national review of missions and clinical programs.

- Educational - Review the content and structure of the educational programs and their relationship to the Department's mission. This review should also focus on the type of manpower that is needed nationally and especially that manpower needed to meet the Department's clinical mission.

- Research - Review the contribution of clinical and HSR&D research elements to society at large and the relationship of research in general to the mission of the Department.

b. *Medical Centers*

Determine which clinical programs are essential and the location of these programs carefully considered in relationship to providing access to quality care for our veteran population.

VAMC mission changes should be addressed by a broad constituency group including members from Congress, veterans service organizations, AAMC, and others to ensure support for change. Such a group would be similar to the kind of group recently authorized by the House of Representatives that allowed the Department of Defense to gain support for closure of its military bases through the use of an external blue ribbon panel.

2. *Funding Methods* - The process by which the Department justifies its needs and the associated resources to OMB needs revision. The current system of budget formulation does not permit the Department to project its needs accurately, and these processes must be redesigned. The distribution of resources within the Department also requires revision and redirection.

3. *Office of Facilities* - The Office of Facilities resides outside the Department of Medicine and Surgery; therefore, it is difficult for the Department to participate in the selection of projects. This issue should be explored and some method derived that will allow a more significant input into selection, sizing, and funding of projects.

4. *Quality-of-Care Issues* - The present QA task force should have its charge expanded to include the following areas:

   a. *Clinical Practice Standards*
      Review reasons for dissimilar clinical practice patterns such as geographic and speciality variations as well as the social and psychological needs of the patient.

   b. *Appropriateness of Care Review/UR Issues*

      Determine the appropriateness of admissions, continued length of stay in various modalities of care and their impact on resource use.

   c. *Internal/External Reviews*

      Review the value of the surveys and minimize duplication of effort. (i.e., JCAHO, GAO, IG, SERP)

5. *Administrative controls* - The increasing requirements generated by Congressional oversight and VACO controls have hindered the flexibility of local VAMC directors to manage. The rationale for these constraints (i.e., FTEE ceiling, personnel services floor, travel limitations) and reporting requirements (i.e., Efficiency Reviews, A-76/MEOs) should be debated with those who impose them on the line officials. Delegation of authority for personnel actions such as RIF authority and furlough action should be given to local managers.

6. *Management Strategy* - The Department has to take a strong leadership position in representing its goals to outside forces such as Congress, OMB, veteran service organizations, etc.. The Department should institutionalize a "Think Tank" group on a permanent basis to formulate and develop strategies that will assist the Department in meeting its strategic goals for the 1990s and beyond.

7. *Change Existing Corporate Structure* - Explore various organizational forms to provide the Department with the flexibility to meet the realities of decreasing dollars and increasing demand. In order to be a competitive provider in the national health care delivery system, different methods by which the VA is compared with other health care providers should be explored.

OPTION NO. A-1

MEDIPP/CONTINGENCY FUNDING

1. *Issue*

Redirect MEDIPP and Contingency Funds withdrawn from FY 1989 Target Allowance. Discontinue the policy of assessing VAMCs or diverting other new budgetary resources for MEDIPP initiatives and non-budget VAMC needs.

2. *Implementation Strategy*

Funds withdrawn from the FY 1989 Target Allowance are not yet allotted to VAMCs. The funds will be redirected for purposes of reducing the budget shortfall.

MEDIPP funding for new initiatives will be based on a zero-sum analysis which can be negotiated intra- or inter-region.

VACO/program contingency funding requests will be supported through issue papers and VAMC consensus processes similar to those used by the RAM Task Force. Consensus must include field funding support.

All VACO/program requests without funding sources will be deferred until the annual Target Allowance and identification of new budget authority therein.

Field or VACO/programs requests which cannot be funded will be reported to the Chief Medical Director, Administrator, and Congressional Committees.

A line item Departmental contingency fund will be sought in the FY 1991 and the out-year budgets.

3. *Pro and Con*

- Pro -

Requires MEDIPP initiatives to be cost effective and/or high priority because projects will be funded through reductions in lower priority programs.

Limits program expansion in an era of budget constraint.

Requires greater attention to trade-off analysis, promoting cost-beneficial actions.

Provides VAMCs greater participation in evaluating VACO program actions.

- Con -

Inhibits shifting of resources between regions based on demand factors.

Limits RD/ADCMD ability to respond to unforeseen budget contingencies.

Funding sources may be unavailable for timely response to critical unforeseen budget requirements.

4. *Savings*

$37 million to be implemented under CMD authority.

OPTION NO. A-2

DEFERRAL OF HIGH-TECHNOLOGY AND JOINT-VENTURE EQUIPMENT

1. *Issue*

In a period of severe budget constraints, a very conservative approach to the purchase of new high-technology equipment should be adopted.

2. *Implementation Strategy*

Develop and communicate a Department policy that such equipment will not be purchased in FY 1989. This action is within CMD authority.

3. *Pro and Con*

- *Pro* -

Equipment accounts will be subject to the same requirements as other accounts to conserve funds in FY 1989 to help meet unfunded personnel costs.

- *Con* -

Will increase backlog of unfunded equipment needs.

Could affect quality of care.

Would eliminate a cost-effective and positively received joint-venture equipment program.

4. *Savings*

$10 million

OPTION NO. A-3

TRANSPLANTS

1. *Issue*

VA should eliminate all contract transplant programs, and support VA inpatient transplants for service-connected veterans only. There will be a moratorium on all new transplant programs.

2. *Implementation Strategy*

Would require change in Department policy.

3. *Pro and Con*

- *Pro* -

The savings from high-cost transplant programs would reduce impact of workload reductions in outpatient and less costly inpatient programs.

This change would signal the inability of the VA to meet demands for high-cost procedures within the budget levels expected in FY 1989.

- *Con* -

Would eliminate life-saving procedures for certain veterans.

Could adversely affect affiliation relationships at some hospitals.

4. *Savings*

$8 million of available VACO reserves could be saved by not using contracts for transplants and up to $4 million in low priority caseload could be reprioritized by VAMCs for local use.

OPTION NO. A-4

RECAPTURE INCREASED COST FROM TARGET ALLOWANCE

1. *Issue*

   The Target Allowance distributed 64 of 200 million dollars in increased cost at the Department level that was attributable to increased .01 All Other costs. A strategy could be employed to apply this $64 million toward the FY 1989 shortfall through a field withdrawal and subsequent redistribution to meet (on paper) other deficits. This strategy would permit the CMD to *freeze* the FY 1989 target at the FY 1988 level of recurring appropriations prior to Target Allowance adjustments.

2. *Implementation Strategy*

   This proposal involves a transaction which would be accomplished by a TDA withdrawal from the Target Allowance.

3. *Pro and Con*

   - *Pro* -

   Permits the CMD the added leverage to say that he was required to take all the field-increased cost to apply toward the VACO documented shortfall in salaries and other accounts.

   - *Con* -

   Field reaction to "*another withdrawal*" is likely to be strong, especially after having received these dollars in the target allowance document.

   The withdrawal will certainly increase the field station shortfall that has accumulated from absorptions in previous fiscal years.

   Field facilities are building their budget plans under the assumption that these dollars will be available to them for increased costs.

4. *Savings*

   $64 million

OPTION NO. B-5

REDUCTION IN DISCRETIONARY WORKLOAD

1. *Issue*

This option develops the concept of discretionary versus non-discretionary workload. The authority for inpatient care in PL 99-272 and outpatient care in PL 100-322 has established similar yet different groups of veterans for whom the Veterans Administration is obligated to provide care. The obligation to provide care is subject to a physician determination that care is required and cannot arbitrarily be demanded by the veteran. The Chief Medical Director is permitted to establish priorities for inpatient care. Priorities have been established in the statute for outpatient care. This option is regarded as a short- and long-range solution to be implemented (managed) in a dynamic way, to accomplish recovery of shortfall dollars that are not recovered by other incremental solutions. It is noted that the method proposed should be studied in greater detail to determine whether an adjustment is necessary based on regional variations in cost of living and CPI and other factors.

The distribution of patient population across regions, and medical centers within regions, is inconsistent in terms of the penetration within the priority groups. It is suggested that rather than eliminating specific low-priority groups, management flexibility can be maintained by defining the level at which discretionary workload cannot be exceeded. This level can vary depending on the size of the shortfall to be addressed. Various levels of care to discretionary workload populations are outlined in Attachment C for outpatient and Attachment D for inpatient workload. These alternatives differ between outpatient and inpatient workloads but establish a level of equity in treatment services for high-priority workload.

2. *Implementation Strategy*

It is inappropriate to suspend care to entire priority groups of veterans (for example, on a given date, no longer provide care to Category C veterans). The alternatives suggested recognize quality-of-care issues, medical-legal issues and, to some degree, ethical issues. The alternatives are based on the assumption that the point at which workload can best be controlled is on patient entry into the system. This approach permits flexibility at the individual patient level while limiting the total level of discretionary care in the aggregate, i.e., workload can be controlled by speciality clinics as opposed to hospital-wide.

The current RAM provides incentives to expand workload within existing resources. Therefore, the RAM requires modification to alter the incentives to increase workload and remove the penalty of a decreased workload. In the short term, use of the RAM should be suspended as a resource allocation system while modifications are developed. To be more explicit workload in FY 1988 and FY 1989 will not be used to determine RAM allocations in FY 1990 and FY 1991.

3. *Pro and Con*

- Pro -

Provides mechanism that allows for selection of a workload level that can be applied consistently across the Department with system-wide parity.

Reduction can easily be quantified in total dollars and FTEE.

Level can be adjusted periodically (budget cycle or otherwise).

Allows for management flexibility at the local level. (High-demand clinics may be subject to implementation of the priorities at a level different from low-demand clinics.)

- Con -

This proposal could lead to misunderstanding among constituent groups as to how the priorities are being applied.

Some medical centers will feel they are carrying an unfair portion of the burden.

Some medical centers may need a multi-year, phased transition.

4. *Savings*

$90.6 million

OPTION NO. B-6

DECENTRALIZE NON-VA WORKLOAD ACCOUNTS

1. *Issue*

Decentralize VACO non-VA workload accounts in order to maximize VAMC efficiencies and allow decisions on choice of health care delivery modalities to be at the lowest possible level. This will be a one-year pilot project.

2. *Implementation Strategy*

VACO funds for Contract Hospital, Fee Medical, Fee Dental, and Community Nursing Home Care will be identified and the majority of funds set aside for high-priority workloads.

Funds not provided to the field will be used to offset budget shortfalls.

Funds provided to the field will be nonrecurring and unearmarked.

Publish an explicit policy to limit contracts for nursing home care treatment of veterans NSC to 90 days.

VACO will have to prepare letters for Contract Hospital and Community Nursing Home Care reprogramming and receive Administrator and Congressional approval.

Additional savings may be possible by aggressive local management of these accounts and would remain at the medical center level.

3. *Pro and Con*

- *Pro* -

It is expected that VAMCs will have direct benefit of program savings.

It is expected that annually budgeted increases will be passed on to VAMCs.

VAMCs will be able to plan workloads and integrate VA and non-VA workloads more effectively.

Year-end uncertainty will be eliminated, as will the need to estimate and establish contingency fund levels.

Action is not statutorily prohibited.

- *Con* -

Congress will strenuously object to Community Nursing Home Care reductions and disapprove the reprogramming request and censure the Agency.

Congress may seek a legislative remedy.

Non-VA workload program size may diminish and OMB may extract resources.

Significant additional administrative costs will be incurred by Regional Director's offices.

4. *Savings*

Approximately $30 million in budget authority can be withheld from VAMCs and applied to the budget shortfall. Implementation without congressional approval can be accomplished by the Agency; however, censure may follow.

VAMCs may realize additional savings which can be used for other purposes. Although these funds will *not* be applied to the system budget shortfall, the result will add to the level of reprogramming.

OPTION NO. B-7

NONRECURRING MAINTENANCE AND REPAIR

1. *Issue*

It may be necessary to utilize up to $122 million in NRM funds out of a total of $182 million in FY 1989 to help meet unfunded pay increases and other essential personnel costs. This could result in serious additional erosion of the Department's plant and facilities.

2. *Implementation Strategy*

A policy decision could be made to divert $122 million of NRM funds to other medical care purposes. A contingency fund of $60 million would be retained to meet the highest priority NRM needs.

3. *Pro and Con*

- Pro -

Would allow additional funds to be utilized to help support medical care shortfalls.

- Con -

Would reduce the overall level of resources devoted to improvement of facilities.

Would further erode Department's plant and equipment.

4. *Savings*

$122 million

OPTION NO. B-8

RESTRICT OVER-THE-COUNTER DRUGS FOR ALL PATIENTS

1. *Issue*

   It may be necessary to identify and restrict medical care funding of lower priority drugs and supplies. The purchase of proprietary (over the counter) drugs and supplies with medical care funds would be restricted as a general Department policy. However, the policy would permit local discretion in making exceptions to the policy.

2. *Implementation Strategy*

   Would require development of a Department policy statement. The timing of the policy and disposition of existing inventories of drugs would need to be considered. The General Counsel should decide whether this policy requires legislation.

3. *Pro and Con*

   - Pro -

   May reduce some perceptions that overuse of drugs by VA patients exists.

   - Con -

   Policy may incur strong veterans service organization resistance.

   Some substitution of prescription drugs for over-the-counter drugs may occur.

   Clinical resistance to the policy may arise.

4. *Savings*

   What qualifies as an over-the-counter drug varies by state; therefore, it is difficult to establish a dollar savings amount. The savings incurred by individual medical centers would be retained to offset local deficits.

OPTION NO. B-9

ELIMINATE CHRONIC OUTPATIENT HOME AND FEE FOR SERVICE DIALYSIS

1. *Issue*

The Department of Health and Human Services (HHS) is statutorily responsible for providing dialysis with end-stage renal disease (ESRD). The Health Care Financing Administration (HCFA) is the agency within HHS that monitors and pays for these services.

HCFA policies and regulations affect the provision of ESRD care in two ways. First, a six-month waiting period is required before care is authorized and payments made. Second, the amount of money that HCFA will authorize for payment for dialysis is limited.

2. *Implementation Strategy*

Veterans currently receiving dialysis, as well as those who are getting dialysis on a fee-for-service basis should be transferred to HCFA. All new veterans requiring dialysis should be subsidized by the VA for the first six-months and then transferred to HCFA if, after the six-month period, they would have been placed on home dialysis or a fee-for-service program. Implementation will require consultation with VA General Counsel and with HCFA.

3. *Pro and Con*

- Pro -

VA hospitals would still retain an acute dialysis capability.

VA hospitals would have flexibility in application of the policy.

- Con -

There would be negative reactions from veteran groups, Congress, VA medical staff and patients.

HHS and OMB may resist the proposal.

4. *Savings*

It is difficult to estimate savings. The savings realized will be available to VAMCs to meet high-priority needs.

OPTION NO. B-10

APPEAL CONGRESSIONAL GUIDANCE TO MAINTAIN EMPLOYMENT AT AIDS-IMPACTED VAMCs

1. *Issue*

   Funds and FTEE have been withdrawn in response to a Department- wide reduction in the President's budget on the FY 1989 Target Allowance from 26 AIDS-impacted VAMCs. The House appropriation FY 1989 markup report language indicates that these VAMCs should not be subject to reductions below FY 1988 levels.

2. *Implementation Strategy*

   The Agency should indicate to Congress that it is not able to comply with the mandate.

3. *Pro and Con*

   - Pro -

   Hospitals other than AIDS-impacted VAMCs will not be "taxed" to accommodate a Congressional mandate.

   - Con -

   Congress may introduce a statutory restriction in place of the report language.

4. *Savings*

   $34.4 million will *not* have to be restored to the AIDS-impacted VAMCs.

OPTION NO. B-11

DELAY ACTIVATIONS OF NEWLY CONSTRUCTED FACILITIES

1. *Issue*

The FY 1989 Budget requested $96 million and 1,882 FTEE for activation of newly constructed facilities. This is the incremental budget estimate which is requested to be added to the FY 1988 activations base. The chart below details this incremental request:

	(000'$)	(FTEE)
Requirements for FY 1989 Projects	185,273	1,514
Less: applied slippage (57%)	-105,021	-1,052
Net New Activations	80,252	462

2. *Implementation Strategy*

No funding would be provided for activating new FY 1989 projects; however, funding would be provided for projects that started in FY 1988 and need annualized funding in FY 1989 to be completed. In addition, prior year applied slippage would be funded. The anticipated savings would be $80,252,000 and 462 FTEE. These actions would require CMD consultation with the Office of Facilities and Administration.

3. *Pro and Con*

- Pro -

Minimal impact would be seen in system workload levels

Quick mechanism for recouping budgeted resources.

- Con -

Savings would be reduced by the amount required to fund VA-furnished, contractor-installed equipment, otherwise construction would be held up and contractor fines would be levied.

Savings would be reduced for utilities, maintenance, and security needed for buildings in a shutdown mode.

Recouping dollars by reducing activations is very inefficient. Not starting construction would make more sense in the long run. The VA would be subjected to much criticism for waste and abuse in spending millions of dollars to construct facilities and then leave them vacant.

The potential savings in activation resources has already been reduced by the unrealistically high slippage rate applied in the budget process.

4. *Savings*

$80 million

OPTION NO. B-12

PAYMENT FOR PRESCRIPTIONS

1. *Issue*

Require the discretionary veteran population to bear either the full or partial cost of prescriptions.

2. *Implementation*

Change the policy in MP-2, part VII, to limit eligibility for medications to veterans described as non-discretionary in Title 38.

3. *Pro and Con*

- Pro -

Potential immediate cost savings.

Potential cost avoidance because patients will now pay for medications and may not request as many prescriptions.

Potential for some small reductions in indirect costs.

This option has been developed based on an estimate at the levels defined earlier for discretionary vs. non-discretionary workload. These levels could be readjusted for different populations of low-priority workload to give different estimates of cost savings.

This option could be implemented as full-cost or cost-sharing method.

In a system where patients bear partial or complete costs, patients will encourage their physicians to prescribe more cost-effective lower-cost medications

- Con -

Significant resistance from veterans service organizations and other constituent groups

Implementation at its most discrete level (30%SC) will be difficult.

Patient inability to bear the payment for medication(s) may lead to eventual hospitalization at higher cost.

Option to allow patient to have prescriptions filled in the community will be difficult to implement due to physician licensing problems.

4. *Savings*

Estimated savings for discretionary workload at $43 million for patients bearing full cost of medication. (If a cost-sharing method is adopted, it is estimated that this population will be served with 6.3 million prescriptions.)

OPTION NO. C-13

DISCONTINUE HCMI AND HOMELESS DOM PROGRAMS

1. *Issue*

Discontinue the Homeless Domiciliary and Homeless Chronically Mentally Ill (HCMI) programs except to the extent that specific appropriations are provided.

2. *Implementation Strategy*

Withhold allotment of funds for HCMI program. Funds were withdrawn on FY 1989 Target Allowance.

Withdraw funds allotted to VAMCs for Homeless DOM program.

Apply funds to other budgetary shortfalls.

3. *Pro and Con*

- *Pro* -

Funds can be applied to higher priority activities.

- *Con* -

Congress has expressed interest in the program and the VA would contradict prior communications.

Congress may express as mandate an appropriations bill committee report.

There will be extremely adverse public relations.

Those homeless returned to the street may reappear as acute medical patients at higher cost.

4. *Savings*

$7.9 million for HCMI.

$10.4 million homeless DOM.

$18.3 million total savings.

OPTION NO. C-14

PL 100-322 AND EXISTING BENEFICIARY TRAVEL PROGRAM

1. *Issue*

   Do not implement PL 100-322 for unfunded and discretionary sections. Additional demands placed on the health care system, for which appropriations are not provided, can *not* be implemented.

2. *Implementation Strategy*

   Section 108 (beneficiary travel) regulations will have to be coordinated with and approved by the Administrator. The Chief Medical Director has authority to defer implementation of all other sections summarized below.

Cost		
Section/Brief	*$000*	*Comments*
105 Health Care Outside USA For SC	660	Defer publication of regulations
108 Beneficiary Travel	43,298	Publish regulations in Federal Register. Revised regulations will also down-size funding requirements for pre-PL-100-322 program (See savings).
113 Mobile Health Care	4,727	Law says resources must be appropriated.
201 Quality Assurance	7,745	Do not expand program activity.
212 Nurse Bonus Pay	140,850	Do not implement bonus regulations. Continue alternative recruitment incentives, including special pay.
Total	$ 197,280	

3. *Pro and Con*

   - *Pro* -

   Agency has authority to refuse implementation.

   The Department will be able to pay for interfacility transfers with beneficiary travel funds.

- Con -

Constituents and employees (Section 212) will perceive as a benefit withheld.

For beneficiary travel, possible roadblocks exist at administrator level and there will be strong disagreement at the national veterans service organizations and Congressional level.

OMB may claim any savings due to beneficiary travel retrenchment.

4. *Savings*

Savings through the deferral of expenditures for sections 105, 113, 201 and 212.	
Sub-total	$153,982
Savings for Section 108, beneficiary travel, include deferral of expenditures for new authority and recoupment of funds available in base for old authority. However, a portion of the base must be retained for inter-facility transfers.	
Deferral for Section 108	$ 43,298
Recoup base	$ 57,603
Less inter-facility transfer	($ 18,500)
Sub-total	$ 82,401
Total savings	$236,383

OPTION NO. C-15

DECENTRALIZE VACO ACCOUNTS (NON-WORKLOAD)

1. *Issue*

   Cease VACO funding for Upward Mobility Program and procurement of gold for central dental labs.

2. *Implementation Strategy*

   CMD decision relayed to Office of Personnel and ADCMD for Dentistry.

   VAMCs may continue to fund Upward Mobility Program at their discretion.

3. *Pro and Con*

   - *Pro* -

   Funds from programs terminated by the CMD will be used to offset other budgetary shortfalls.

   - *Con* -

   Such action on the Upward Mobility Program would have perceived negative implications for the EEO program.

4. *Savings*

   $3 million for the Upward Mobility Program based on Office of Personnel concurrence.

   $230,000 in gold procurement at discretion of CMD.

   Total savings $3.2 million.

OPTION NO. C-16

A MORATORIUM ON A-76 STUDIES, EFFICIENCY REVIEWS, FDPs — AND OTHER SPECIAL STUDIES

1. *Issue*

   Principal management and administrative attention in FY 1989 should be devoted to budget execution and management of the funding shortfalls. Substantial administrative reporting and special analytical burdens during this period should be minimized. VAMCs need to have maximum flexibility in order to better respond to the current crisis. During FY 1989 a moratorium would be placed on such studies and reports. For example, the moratorium would cover Facility Development Planning (FDP), A-76, MEO Studies, Efficiency Reviews (ER), and Staffing Guidelines.

2. *Implementation Strategy*

   Would require Agency-level policy change.

3. *Pro and Con*

   - *Pro* -

   Would relieve VAMC management of supervising nationally mandated studies and allow attention to be focused on budget execution and other local priorities.

   - *Con* -

   Flies in the face of strong VA policy (e.g. FDPs) and presidential policy (e.g., A-76 and ERs)

4. *Savings*

   $10 million (available to field for higher priority needs)

OPTION NO. D-17

REPRIORITIZE MINOR APPROPRIATIONS PROJECTS

1. *Issue*

The FY 1989 VA Budget contains $182 million for the Nonrecurring Maintenance and Repair Program (NRM) and $149 million for the Minor Construction Program for a total of $331 million to maintain and upgrade facilities. From this combined amount $60 million of NRM funds should be set aside for critical and emergency repair projects. The remainder ($122 million) of the NRM account can be temporarily redirected to higher priority medical care needs.

The Department should reprioritize the use of minor appropriation funds to accomplish "maintenance-oriented" projects or approved minor projects.

2. *Implementation Strategy*

The reprioritization of the minor construction appropriation would require consultation with the Office of Facilities and the Administrator.

3. *Pro and Con*

- *Pro* -

The re-orientation and prioritization of the minor appropriation will make a substantial contribution to the budgetary shortfall in the NRM accounts.

- *Con* -

There will be some resistance within VA to the re-prioritizing of planned minor construction projects in order to support shortfalls

4 *Savings*

This savings of $122 million has been accounted for in the Nonrecurring Maintenance and Repair Option B-7

OPTION NO. D-18

MANDATED EMPLOYMENT CEILING AND PERSONAL SERVICES FLOOR

1. *Issue*

Mandated Employment Ceiling and Personal Services Floor.

2. *Define Issue*

The President's budget and the House restoration of $6,634,038,000 personal services floor will not support the mandated Congressionally assigned FTEE ceiling of 194,140 FTEE. Additional unfunded mandated requirements ($395 million), such as within-grade increases, health benefits, pay raises and PL 100-322 further hinders the ability of the Department to maintain 194,140 FTEE assigned ceiling. The proposed Congressional personal services floor of $6,534,036,000 for FY 1989 will only support 183,685 FTEE, or 11,127 less than the Congressionally assigned ceiling.

3. *Implementation Strategy*

Reduce FTEE ceiling to a funded personal services floor of $6,634,038,000 to support a level of 183,685 FTEE. This is 11,127 FTEE less than the assigned ceiling of 194,140.

4. *Pro and Con*

- Pro -

Prevent anti-deficiency status.

Maintain (01) all other accounts for intended purposes.

Workload will be maintained at a level supportable by proper
balance of FTEE expenditures and all other expenditures.

- Con -

Unable to accomplish budgeted workload: it will be reduced from FY 1988 level.

May further impact on 90,000 bed floor.

Will not meet the Congressionally assigned FTEE ceiling of 194,140.

Could require authority to initiate personnel actions to reduce FTEE ceiling to affordable levels. (i.e., RIF, furlough, early outs, hiring delays, employment freeze)

5. *Savings*

$395 million.

ATTACHMENT A

LIST OF SUGGESTED OPTIONS CONSIDERED BY CMD'S TASK FORCE ON FY 1989 OPERATIONAL SHORTFALLS

ITEM	BUDGET OPTION
1	Restrict Funding for PL 100-322
2	Eliminate Funding for Discretionary Items (PL 100-322)
3	Eliminate Funding for Beneficiary Travel
4	Control Workload to Predetermined Ratio of Mandatory Wk
5	Reallocate Community Nursing Home Workload
6	Reallocate Contract Hospital, Fee Med/Dent Dollars/Workload
7	Decentralize Recurring VACO Accounts
8	RAM Derived Funds
9	Identify VAMC funded program initiatives not centrally authorized
10	Stop Activations of Newly Constructed Facilities
11	Balancing Accounts - Reduce Equipment and Maintenance
12	Implement a Regional Capitation Allocation System
13	Improve Utilization of VA Facilities w/A-0-C Protocol
14	Reduce Support to Medical Residency Program
15	Reduce Research and Education/Training by 5-10%
16	Standardize Procurements for Economies/Efficiencies
17	Eliminate Renal Transplants, Home & Fee for Service Dialysis
18	Elimination of New Satellite OPCs
19	Delay in Filling Vacant Positions
20	Employee Furloughs as Last Resort
21	Rigorous Review of VAMC Missions
22	Medical Center Program and Management Consolidation
23	Review/Analyze ALL VACO Accounts for Direct Care Distr.
24	Moratorium on RMEC Programs Involving Travel
25	Severely Curtail Meeting Travel
26	Eliminate Over-the-Counter Drugs for Outpatients
27	Reduce Central Office, Med. District and Reg. Office Staffs
28	Reduce Total Number of Specialized Tertiary & Card. Cath Prg
29	Eliminate All Dental Care Unless Adjunct to Medical Care
30	Close Medical Center(s)
31	Eliminate Comprehensive Rehabilitation
32	Close Vet Centers
33	Expand Mgt Efficiency Pilot Flexibility to All Facilities
34	Do Not Fund Any New GRECC Initiatives

ATTACHMENT A

LIST OF SUGGESTED OPTIONS CONSIDERED BY CMD'S TASK FORCE ON FY 1989 OPERATIONAL SHORTFALLS

ITEM	BUDGET OPTION
35	Defer MEDIPP Initiative Funding until Shortfall is Met
36	Hold Implementation of New Legislative Initiatives
37	Limit CNH Placements to 90 day contracts.
38	Limit CNH placements to service-connected veterans only.
39	Limit CNH placements to ser-conn. vets for s-c conditions
40	Eliminate all over-the-counter drugs to all veterans.
41	Eliminate all drugs to Category B and C outpatients.
42	Consolidate patients on fewer wards.
43	Decentralize Clinic of Jurisdiction non-recurring funds
44	Increase procurement standardization at the District level.
45	Reduce in-patient adms. by use of established VA Priorities.
46	Limit beneficiary travel to only interstation transfers.
47	Use capitation system with RAM and appropriateness of care
48	Do not fund shared high tech equipment
49	Adjust FTEE floor
50	Decentralize and reprogram community Nursing Home Funds
51	Reduce non VA workload by 10%
52	Drop prescription drugs for all outpatient care
53	Defer all FY 1989 Construction obligations for one year
54	Discontinue RAM ,freeze base,withold increase cost/usage
55	Eliminate unnecessary beds/convert beds to obviate const.
56	Eliminate national contracts for cost studies A-76/MEO
57	Consolidate Review Mechanisms - SERP & UR
58	Dental Treatment - Restrict to SC & adjunct treatment only
59	FEHB Costs - Negotiate a national contract for FEHB.
60	Wage Grade Costs - Mechanism to set levels needs reviewing
61	Consolidation of Programs - Duplicate programs combined.
62	Chaplain Service - Eliminate Chaplain Svc.
63	Admin. Training Pro. - Reduction in length of programs.
64	Prosthetic Eligibility-Elig. of pros. & med.sup. restricted.
65	Pharm.Mail-Out Ctrs.-Reg. Pharm. ctrs. should be estab.
66	Assigned Bed Levels-More realistic Congressional bed levels.
67	Reduction in Force-Local RIF authority recommended.
68	Title 38 Discipline-Local authority should be granted.
69	Military Support-Nat'l initiative to provide svcs. to mil.

LIST OF SUGGESTED OPTIONS CONSIDERED BY CMD'S TASK FORCE ON FY 1989 OPERATIONAL SHORTFALLS

ITEM	BUDGET OPTION
70	Recalculate FTEE levels, using .01 A/O contract $ for PS
71	Early Out Proposal
72	Eliminate/reduce dialysis
73	Reduce/Consolidate Drug & Alcohol Inpt. Programs
74	Stop FDP Process
75	Examine SERP and consider suspension or elimination.
76	Charge NSC for All Medications on Sliding Scale Set By VA
77	Suspend MEDIPP
78	Suspend MEDIPRO
79	Discontinue Staffing Guidelines Development
80	Discontinue Management Efficiency Reviews (MEOs)
81	Restrict Organ Transplants to SC Patients Only
82	Eliminate District Staffs
83	Consolidate Alcohol and Drug Treatment Programs
84	Elim. all Pass Through Accts.& Estab. True Cost Acctg. Sys.
85	Suspend Shifts in RAM for FY89&90 w/Input from Reg. to 10B
86	Include Doms. in 90,000 Bed Level w/Potential of Closures

CMD'S TASK FORCE ON FY 1989 OPERATIONAL SHORTFALLS

RECOMMENDED BUDGET OPTIONS FOR FY89

ITEM	BUDGET OPTION	SAVINGS		DECISION CATEGORY			
				CMD		ADMIN	LEGISLATIVE
		FTEE	($000)	IMMEDIATE	CONSULTATION		
A1	MEDIPP/CONTINGENCY FUNDING	750	37,000	YES			
A2	DEFER HI TECH/JOINT VENT EQUIP		10,000	YES			
A3	TRANSPLANTS		8,000	YES			
A4	RECAPTURE COST FROM TA		64,000	YES			
	SUBTOTAL	750	119,000				
B5	REDUCTION IN DISCRETIONARY WKLD	1,966	90,634		YES		
B6	DECENTRALIZE NON-VA WKLD		30,000		YES		
B7	REPRIORITIZE NRM		122,000		YES		
B8	RESTRICT OVER-COUNTER DRUGS		UNKNOWN		YES		
B9	ELIMINATE CHRONIC HOME/FEE DIALYSIS		UNKNOWN		YES		
B10	APPEAL CONGRESSIONAL AIDS FENCE		34,400		YES		
B11	DELAY ACTIVATIONS	462	80,252		YES		
B12	PAYMENT FOR PRESCRIPTIONS		43,000		YES		
	SUBTOTAL	2,428	400,286				

CMD'S TASK FORCE ON FY 1989 OPERATIONAL SHORTFALLS

RECOMMENDED BUDGET OPTIONS FOR FY89

ITEM	BUDGET OPTION	SAVINGS		DECISION CATEGORY			
				CMD		ADMIN	LEGISLATIVE
		FTEE	($000)	IMMEDIATE	CONSULTATION		
C13	DISCONTINUE HCMI/HOMELESS DOM		18,300			YES	
C14	PL100-322 & BENE TRAVEL		236,383			YES	
C15	DECENTRALIZE VACO WKLD		3,389			YES	
C16	MORATORIUM ON A-76, ETC.		10,000			YES	
	SUBTOTAL		268,072				
D17	REPRIORITIZE MINOR CONST APPROP.						YES
	TOTAL	3,178	787,358				
D18	EMPLOYMENT REDUCTION - 11,127 FTEE		395,820			YES	

OUTPATIENT WORKLOAD REDUCTION

REGION	FY88 PROJECTED TOTAL	FY88 PROJECTED NON-DISCR 12 MOS.	FY88 PROJECTED DISCRET 12 MOS.	% DISCRET	DISCRET AT 8.9%	VISIT REDUCTION	RESOURCE CUT AT $87	PERSONAL SERVICES	FTEE CUT AT 33.6K
1	3,271,755	2,943,138	328,617	10.0	290,717	(37,901)	(3,297,359)	(2,308,151)	(68.9)
2	2,864,513	2,582,065	282,448	9.9	254,531	(27,917)	(2,428,809)	(1,700,167)	(50.8)
3	2,808,276	2,558,742	249,534	8.9	249,534	0	0	0	0.0
4	2,907,423	2,498,450	408,973	14.1	258,343	(150,630)	(13,104,796)	(9,173,357)	(273.8)
5	2,343,547	2,005,844	337,703	14.4	208,239	(129,464)	(11,263,351)	(7,884,346)	(235.4)
6	3,243,933	2,843,093	400,839	12.4	288,244	(112,595)	(9,795,751)	(6,857,026)	(204.7)
7	2,999,436	2,640,110	359,326	12.0	266,519	(92,807)	(8,074,188)	(5,651,932)	(168.7)
TOTAL	20,438,883	18,071,443	2,367,441	11.6	1,816,127	(551,313)	(47,984,254)	(33,574,978)	(1,002.2)

Source: COIN OPS Report RCS 10-0004, 4/30/88

INPATIENT WORKLOAD REDUCTION

REGION	DISCHARGES			DISCRET DISCHS AT 1.5% OF TOTAL	DISCH CUT	RESOURCE CUT $4,206/ DISCH*	PERSONAL SERVICES AT 75.73%	FTEE CUT**
	TOTAL*	NON-DISCRET	DISCRET					
1	129,567	126,611	2,956	1,944	(1,012)	(4,256,472)	(3,223,426)	(96.2)
2	156,353	153,817	2,536	2,345	(191)	(803,346)	(608,374)	(18.2)
3	179,160	176,534	2,626	2,687	61	256,566	194,297	5.8
4	148,829	145,121	3,708	2,232	(1,476)	(6,208,056)	(4,701,361)	(140.3)
5	151,704	146,121	5,583	2,276	(3,307)	(13,909,242)	(10,533,469)	(314.3)
6	132,317	127,605	4,712	1,985	(2,727)	(11,469,762)	(8,686,051)	(259.2)
7	172,909	168,822	4,087	2,594	(1,493)	(6,279,558)	(4,755,509)	(141.9)
TOTAL	1,070,839	1,044,631	26,208	16,063	(10,145)	(42,669,870)	(32,313,893)	(964.3)

*SOURCE: •Total Acute Discharges, PTF 87 (Med, Surg, Psych, Neuro & Rehab)
•Resources (Direct & indirect expenditures associated with above bed sections as reported in FY 87 Cost Distribution Report)

**Based on average salary of $33,512

CHIEF MEDICAL DIRECTOR'S
TASK FORCE
ON
FISCAL YEAR 1989 OPERATIONAL
SHORTFALLS

Members:

Bell, Barry L.	Director, VAMC Portland, OR - CHAIRMAN
Bourett, Archie	Director, VAMC Grand Junction, CO
Malphurs, Fred	Deputy ADCMD for Programs and Operations, VACO
Musser, A. Wendell, M.D.	Chief of Staff, VAMC Atlanta, GA
Regan, Peter, M.D.	ACMD for Academic Affairs, VACO
Thompson, Donald B.	Regional Director, Southeast Region
Zamberlan, Al	Regional Director, Great Lakes Region

Staff:

Furlan, Allen	Deputy Director, Resource Management, VACO
Gregg, James	Deputy ACMD, Strategic Planning, VACO
Melander, Evert	Health Resource Management Staff, VACO
Perreault, Robert	Director, Medical Administration, VACO

CHART 1

Medical Care Budget Authority
Current vs. Deflated (1977) Dollars

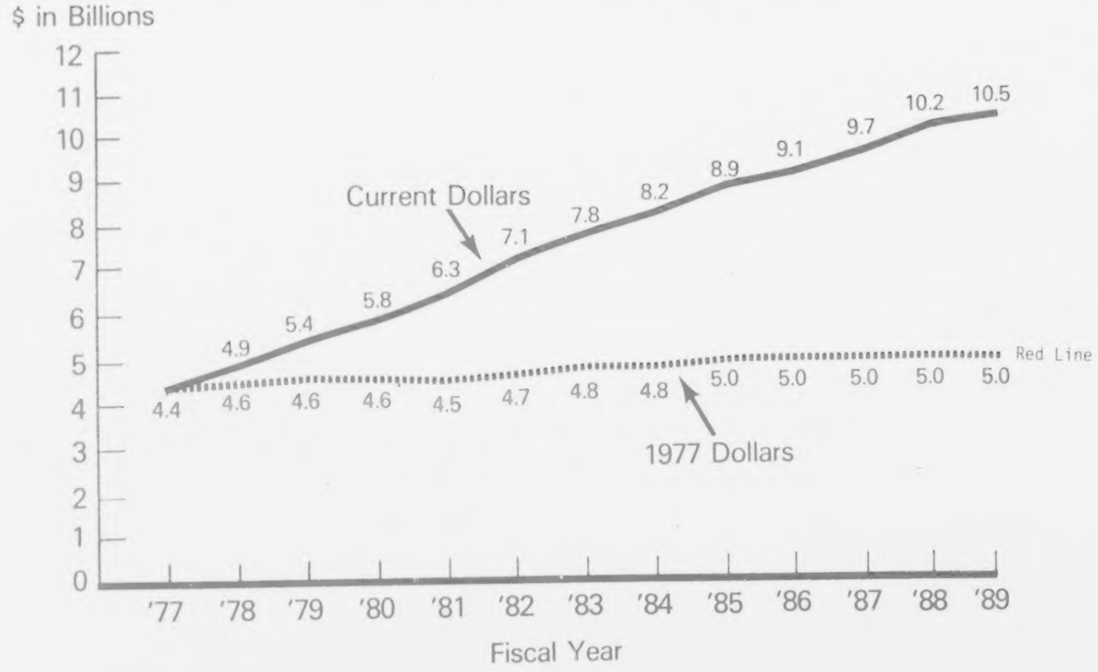


CHART 2

Average Number of Operating Beds by Type VA Hospitals

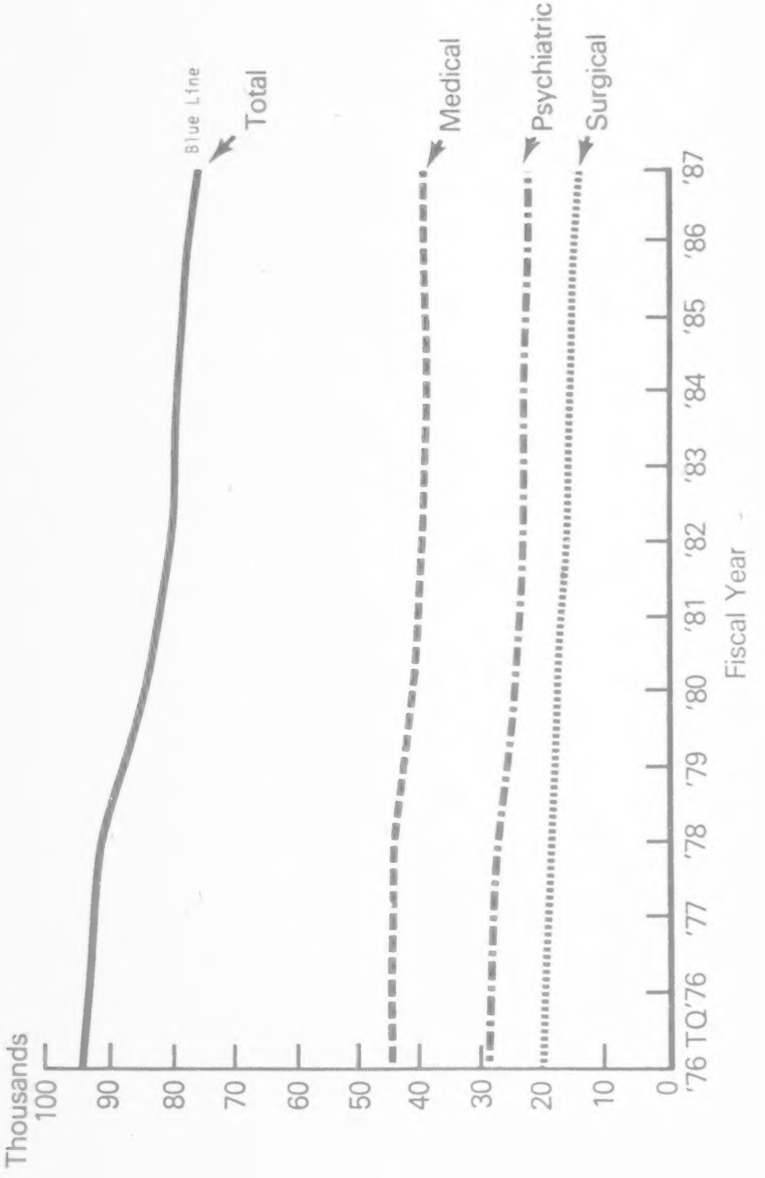


CHART 3

On-Duty Employment Levels - Physicians and Nursing Staff

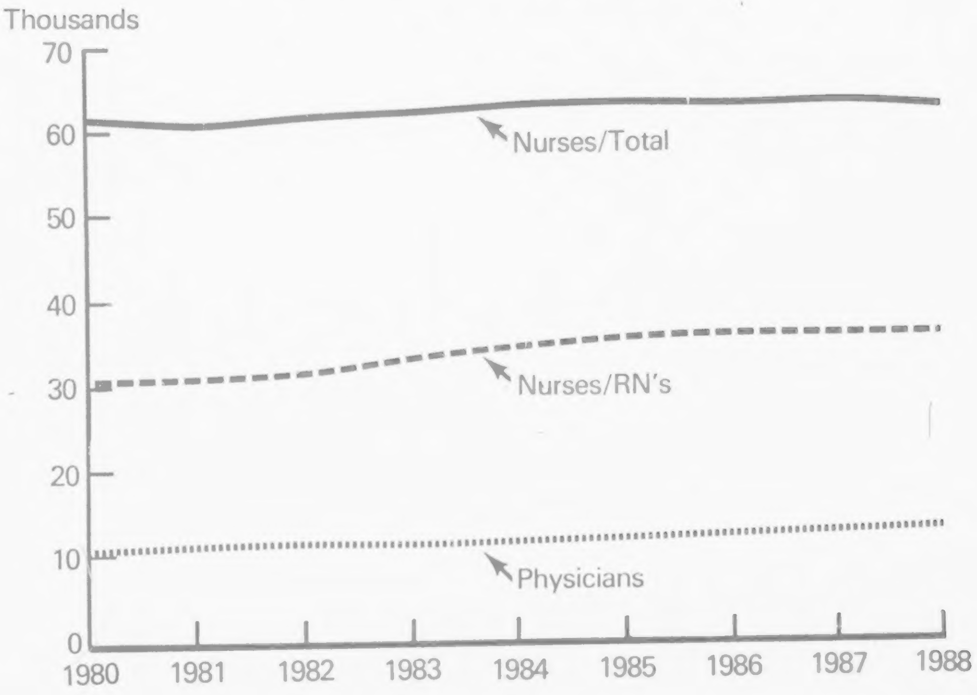
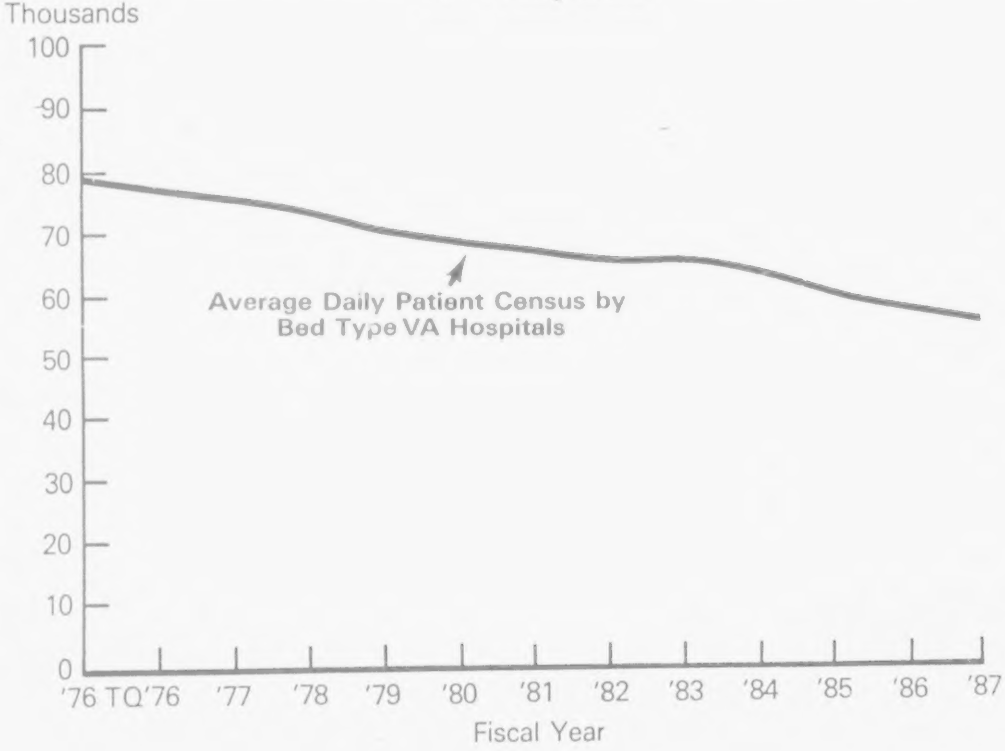


CHART 4

Average Daily Patient Census by Bed Type VA Hospitals



Statement of

The American Legion

1608 K STREET, N. W.
WASHINGTON, D. C. 20006

by

SAMUEL J. WALSH, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION

and

JOHN F. SOMMER, DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

before the

COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE

on

VA HEALTH CARE OVERSIGHT, FUNDING PROBLEMS

SEPTEMBER 9, 1988

STATEMENT OF JOHN F. SOMMER, JR., DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE
SEPTEMBER 9, 1988

Mr. Chairman and Members of the Committee:

The American Legion is appreciative of this opportunity to express its concern regarding the inadequate funding and management problems facing the Veterans Administration's Department of Medicine and Surgery.

Through site visits made to VA medical centers across the country, conducted by our National Field Representatives, and through information provided by our Department Adjutants, Department Service Officers and other concerned American Legion officials, a picture of fiscal distress is becoming apparent as VA medical centers strive under the most difficult of circumstances to provide quality medical care to veterans. As the fourth quarter of FY 1988 is now underway, we are aware of serious budgetary shortfalls at many VA medical centers.

A partial list of the problems include bed closures, curtailment of certain treatment programs, reduction of treatment to nonservice-connected veterans, excessive waiting times for admission and to be seen at certain outpatient clinics, and the closing of some clinics, just to name a few. We will discuss certain of these problems in more detail in a moment.

As we understand it, a myriad of factors are responsible for the current fiscal crisis. It is a fact that the budget for the Department of Medicine and Surgery has been decremental over the past several years. Experience verifies this as we visit medical centers which have continually attempted to do more with less. Dollars withdrawn for the one percent productivity incentive, workload reductions, Gramm-Rudman-Hollings reductions, as well as escalating costs for drugs, supplies, and medical technologies, all have created a scenario where the budget has progressively become totally inadequate. What we are witnessing today, is the cumulative effect of several years of funding deficits, coupled with the fact that the demand for care continues to increase. Through the end of July, the actual inpatient workload was averaging four percent above the fiscal year-to-date plan and the outpatient workload was approximately three percent above plan.

Mr. Chairman, as was recently stated by a VA official, "the level of budgetary anxiety in the field today is higher than ever before."

The Department of Medicine and Surgery is in a predicament today whereby workload caps have been in effect at some facilities, and additional budgetary restraints relating to pharmacy and prosthetics services, have been imposed at others, as mentioned a moment ago. We are aware that several facilities have imposed Category C restrictions, and others are considering such restrictions.

Several current examples and vivid illustrations of field level constraints that have been reported to us are as follows:

- VAMC San Diego and Mission Valley Outpatient Clinic have discontinued treating Category C outpatients after one visit. The alternative for a Category C veteran is to seek treatment in the community.

- Various facilities are out of prosthetics funding, one example being Nashville. These facilities are delaying furnishing prosthetics equipment as ordered, from quarter to quarter.

- A policy of not providing prosthetics equipment to nonservice-connected outpatients has been in effect at the Boise, Nashville, Wichita and San Francisco VAMCs.

- A Halfway House in Miami, Florida, treating substance abuse patients, was closed on July 1, citing no available funds.

- The Washington, DC and the Biloxi, MS VAMCs were among those which were unable to pay community nursing home contract costs, although we have been advised that Washington, DC has now resumed placing veterans in community nursing homes.

- One of two rural health care clinics in Utah was closed, effective July 1. The other clinic is under budgetary scrutiny and is expected to be closed in September.

- Elective surgeries are delayed for many veterans, some up to a 25-week wait (based on the VA's own survey).

During a recent official visit in Des Moines, Iowa The American Legion's then National Commander John P. "Jake" Comer learned of the move to limit access to all Category B and C veterans at the Iowa City VAMC, and immediately called the office of the Administrator of Veterans Affairs expressing outrage over such a policy. Shortly thereafter, Medical Center officials in Iowa City and other facilities where similar restrictions had either been implemented or were being considered, were reportedly told to reverse their decisions and to resume the provision of care based on established eligibility guidelines.

The National Commander was unaware at the time he placed the call of the similar restrictions being placed in effect at, among others, the Boise, Fargo and San Diego Medical Centers. As National Commander Comer has stated, the proper way to deal with such realities is for the Veterans Administration to submit realistic budgets to Congress each year, and not continue to say they can make do.

Mr. Chairman, these examples represent only some of the problems that have developed as a result of inadequate funding.

We understand that medical centers are shifting funds from equipment and non-recurring maintenance accounts to help fortify medical care programs and to support personnel salary costs. A facility may be able to operate in this manner for a year or two, but after a short while, the facility's physical plant, technology requirements and inventories will suffer. Additionally, operating beds have been placed out-of-service due to inadequate staffing, or due to an effort to economize resources. During a recent VAMC survey visit, a Field Representative observed first hand that eight non-acute psychiatric patients, who otherwise would have been admitted, were told to return the following day because no beds were available.

The number of operating beds out-of-service due to system-wide staffing vacancies are numerous and, in many instances, are causing unnecessary delays in the patient admission process. Oftentimes, a bed count has to be conducted to determine the number of daily discharges, so a decision can be made on how many beds are available and, thus, how many patients can be admitted.

Mr. Chairman, it is a well known fact that during recent visits to sixteen VA medical centers, Congressional staffers found that 1,771 hospital beds which were officially designated as operating beds were not available for the provision of medical care due to insufficient staff. Other beds were also closed for other reasons. It must be kept in mind that this is only a fraction of the total number in the system.

It has been estimated that the shortfall for FY 1989 may be as much as $819.3 million or more for the Department of Medicine and Surgery. Unless a supplemental appropriation is provided, we can only anticipate that, based on the projected funding deficit, even more draconian actions will be taken throughout the medical care system to reduce spending.

As you are aware Mr. Chairman, the recently passed supplemental appropriations bill, H.R. 5026, contained $508 million for the VA for FY 1988, including $498 million for the compensation COLA that was approved in December 1987. The remaining $10 million is earmarked for VA health care. In addition, $21 million has been reprogrammed from the Home Loan Revolving Fund to the Department of Medicine and Surgery. However, the entire $31 million is to fund the provisions of PL 100-322 for the remainder of FY 1988.

Mr. Chairman, The American Legion has historically expressed the importance of maintaining an appropriate funding level for VA health care programs. Today, we are witnessing an increasing level of frustration on the part of VA hospital officials and related health care personnel, as they attempt to provide high standards of health care to eligible beneficiaries. This is in addition to the frustrations experienced by the veterans themselves. Contrary to being told by Veterans Administration officials in Washington that resources are sufficient to adequately carry out the mission of the Department of Medicine and Surgery, the only conclusions we can reach are that either resources are not well managed, or the requested funding levels have been insufficient to begin with. The shortfall in VA funding is real and no amount of wishful thinking will make it otherwise. As stated at the outset, The American Legion believes that the decremental - or straight-line funding that has been provided for medical care over a period of years is the major problem.

The fact of the matter is that the decremental budgeting has had an adverse effect on patient care and will continue to erode the quality, quantity and timeliness of health care services provided to veteran beneficiaries. We sincerely trust that VA officials will explain to this Committee the true extent of the problems that are being experienced in the medical care system, and that they will accurately portray the budgetary requirements of the Department of Medicine and Surgery.

Mr. Chairman, this concludes our statement.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

STATEMENT OF

DENNIS M. CULLINAN, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

WITH RESPECT TO

HEALTH CARE RESOURCES

WASHINGTON, D. C. SEPTEMBER 9, 1988

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.2 million members of the Veterans of Foreign Wars of the United States, I wish to thank you for affording us this opportunity to present our views as to whether the Veterans Administration's Department of Medicine and Surgery possesses sufficient resources to provide quality patient care on a timely basis to all eligible veterans. This subject is of great concern to the Veterans of Foreign Wars in light of the fact that the VA's already over-taxed health care system must soon answer the needs of our swiftly growing older veterans population. The VFW extends its appreciation and thanks to this Committee for conducting this hearing to ensure this nation's veterans health care needs are properly provided for by the Veterans Administration.

For a number of years now the VA has misled the veteran public with respect to the number of beds in VA medical centers (VAMCs) which are actually

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VFW MEMORIAL BUILDING ● 200 MARYLAND AVENUE, N.E. ● WASHINGTON, D.C. 20002-5799 ● AREA CODE 202-543-2239

"operating," that is, available for the medical care of veterans. While the VA has managed to provide adequate health care over this period, the capacity of its medical centers to properly provide health care at current levels has been stretched practically to the breaking point.

The VA is mandated by law to maintain 90,000 operating beds in its medical system. These beds are needed to provide for the veteran population as well as to maintain a contingency capacity to assist the Department of Defense in time of war or national emergency. For reasons known only to certain VA bureaucrats and a number of budget slashers at OMB, the VA has maintained the fiction that they are in conformance with the law. The truth of the matter is, however, those beds are simply not there.

There has been reference within the VA for several years to the concept of "phantom beds." Phantom beds are those which are officially listed on paper as operating beds for the purpose of complying with the requirements contained under Title 38, USC, but which are actually not staffed and available for patient care. By far and away, and despite official denials, the primary reason for the large discrepancy between paper and actual operating beds, "phantom beds," is the lack of personnel to staff them. This has been borne out through the site visits of our VFW Field Representatives, as well as by other informational sources available to us.

As you know, a report from the recent site visits to 16 VA medical centers by a group of House Veterans' Affairs Committee staff members provides graphic evidence of the problem. Of the 14,939 beds authorized through the 16 visited VAMCs, 12,960 were officially counted as operating, that is available for veterans' health care. However, from out of this reduced total only 11,011 were actually available or operating. So just within those 16 VA hospitals, we have a total of 1,949 "phantom beds" of which 1,771 were identified by hospital management as closed due to insufficient staff. Of course, the problem of closed beds is not the same at all hospitals; three individual hospitals within the survey have no bed shutdown due to staff shortages. The report indicates the proportion of operating beds which are closed due to inadequate staff at the individual hospitals range from 2.5 percent to 36.3 percent. But, taken as a whole, the problem is very serious indeed. In hospitals that do have staff shortages leading to closed beds, the average proportion of operating beds which are not adequately staffed "phantom beds" is 19.1 percent. As it now stands, there are considerably fewer operating beds within the VA system than are authorized, and of that reduced number a substantial percentage would seem to be "phantom beds" which exist only as a statistical fiction rather than as an actual health care resource.

At the very heart of this terrible situation is the lack of adequate funding. Utilizing information provided by the VA, the Congress has provided VA budgets in recent years designed to support slightly in excess of 194,000 full-time employees. In order to adequately provide for VA personnel costs, the Congress, and the VFW places special emphasis on the tremendous effort and leadership exercised by this Subcommittee in this regard, has in fact consistently exceeded the personnel funding requested by the Administration. However, it is only now becoming apparent to what extent funds for VA medical care have gone increasingly to pay personnel costs in order to make it possible for the VA to attract and retain skilled medical staff in competition with the private sector.

Special salary rates have gone a long way toward enabling VA medical centers to attract and retain scarce medical personnel in the highly competitive employment market. However, since the individual medical centers must absorb the costs of these special pay rates, reductions in certain other areas have been made to pay for them. Out of the 16 hospitals included in the House survey, 12 report that funding sources are inadequate for the special salary rates that have been put in place. Thus, there is a dilemma wherein the solution designed to resolve staffing problems has itself created other staffing problems by consuming a large share of the available personnel and health care dollars.

In the report it is stated, "Funds to meet the new payroll costs have largely come from replacement equipment and maintenance and repair accounts, leaving these latter needs unmet. The decision of hospital directors to transfer funds from other operating accounts to fund personnel costs have made it possible for the VA medical care system to continue functioning. However, having exhausted such accounts, the hospitals now have no recourse but to reduce capacity. In the near term, inadequate funds for equipment and maintenance are likely to further reduce both capacity and efficiency and to threaten the quality of care." It is the VFW's position that beds without personnel and other resources necessary to provide care should not be tallied among actual operating beds.

One now familiar OMB ploy to justify reducing the VA's health care capability is to cite the relatively low average daily inpatient census, roughly 55,000, for the VA nationwide. However, with beds officially "operating" on paper but actually unusable, it is no surprise that VA occupancy rates appear to be low. The demand for health care from the VA by veterans is rising and will continue to rise, and it is the VFW's contention that if there were more VA health-care beds actually available and operating the patient census would be considerably higher. By reducing the VA's actual ability to provide health care and thereby artificially reducing its work load, OMB has fabricated the justification to further reduce VA health care capability.

At this point in time, the majority of all VA medical centers are facing a critical shortage in operating funds. Exacerbating this already critical situation is the impact of the diversion of operating funds of the individual medical centers to other DM&S departments and areas over the last few years. This has ensued directly out of OMB having mandated an arbitrary and burdensome one percent "productivity improvement" levy and requiring VA absorption of a substantial portion of the annual COLA pay raise for employees. As a result of this, VA hospitals are faced with a situation where they have no further resources on which to draw and will soon be unable to recruit and retain the health-care personnel needed to prevent further bed closures and reductions in the ability of the VA to deliver medical care.

It is now frighteningly evident to us that the VA's "phantom beds" are not only reducing its current health care capability, but are also contributing to the further erosion of the VA health-care system by creating the harmful and deceptive appearance of a low patient census. The VFW is adamant that only hospital beds which are properly staffed and funded should be counted as operating beds, we also urge that the VA be provided with additional funding with which to meet their personnel demands. If this does not happen, it is our assessment that before this fiscal year is out the amount and quality of health care provided to this nation's veterans will severely degenerate.

The VFW has learned that nurses critically needed by the Veterans Administration are not there. Registered nurses, licensed practical nurses and nursing assistants are absolutely crucial to the quality health care system we demand of the Veterans Administration. They are the professional foundation upon which the whole medical structure depends for nurturing of the ill and infirm.

Although there are men sharing this noble profession of nursing as well, the primary care givers in our Veterans Administration Medical Centers are women. They stand alert to the slightest falter in a patient's vital signs in the many Intensive Care Units. It is their caring touch and confident smile to which thousands of veteran patients respond each day on the various wards. As recipients, we cannot be more grateful for the tremendous strides and the sophisticated technological explosion which has served medicine so well in the latter half of the twentieth century. Nevertheless, it is fair to state that our impressions of care received, and the will to hang in there and fight back toward the road to recovery, are still formed and nurtured by the "hands on" ministrations of the nursing staff. They are the health professionals most "real" to us and veteran patients. Unhappily, there is evidence that their ranks are thinning nationwide.

The expanding workplace and new horizons for women may be a principle underlying cause for the now current reduction in enrollment in nursing schools. As the general health of our population improves, and as the percentage of older citizens increases, when the need for hospitalization strikes today's patients, they tend to be sicker. Therefore, intensive care beds appear to have been expanding geometrically. This high stress environment calls for specialty nurses who are increasingly subject to an effect which they aptly call "burnout." Thus, the curious paradox that three desirable elements, that is, a longer life span for the population in general, expansion of opportunity for women and increasingly sophisticated medical techniques, combine to conspire against the care giver whom we cannot do without.

Which brings us to the area of our first concern, the nurse professional caring for our veterans in the nationwide VA health care delivery system. The Veterans Administration has to compete for the needed nursing staffers to provide quality care to our veterans. As is patently obvious, when the pie shrinks, somebody has to be on the losing end. We have got to ensure that it is not the VA, whose mission it is to provide for our veterans.

Since, as noted earlier, this situation has struck before, a long-term solution was clearly required. The VFW was under the misapprehension that the mechanisms for a long-term solution were in place. That mistaken assumption was based upon the enactment of Public Law 96-330 in August 1980. In recognition of a nationwide nursing shortage which was reaching crisis proportions in the late 1970s, Congress mandated a pilot program and study to "Evaluate the effectiveness of taking various administrative actions on the VA's recruitment and retention efforts related to nursing personnel, including registered nurses, licensed practical or vocational nurses, and nursing assistants." In its deliberations leading up to the passage of that law, the sense of the Congress was expressed as follows: "It is the Committee's expectation that by undertaking the mandated pilot program and study, the VA should generate significant data on which actions have a cost-effective impact on the agency's recruitment and retention efforts directed at nursing personnel and that this information should be helpful in markedly improving the agency's success in recruiting and retaining such personnel."

The required study and pilot program were duly carried out. A number of recommendations followed. In addition to pay inequities and other problem areas identified, we have narrowed those recommendations to three core areas which impact most on nurse morale and effectiveness. Simply stated, those three are: not enough nurses to do the job; lack of tuition reimbursement to upgrade skills; and inadequate support services to permit the nursing professional to concentrate her attention on the patient.

The latter issue needs a little expansion. The thrust here is that if the nurse is to focus her attention upon you, the patient, an adequate number of people and machinery need to be in place as ancillary support. This includes, but is not limited to, pharmacists, housekeepers, ward secretaries, social workers and computer enhancement for physician's orders and other clinical data.

At present, Special Salary Rate Request Review Process has been imbued with a sense of urgency and we are assured that action is being taken in those areas where the VA is losing nurses and futilely running employment ads without takers. For the long-term a Survey of Health Occupations Staff was fielded in early December 1982 to "collect data to assess recruitment and retention trends among several VA health occupation." That is intended, we are told, to form the basis for the long range plan to frustrate cyclical shortages. We are afraid that the VA is already too far behind the power curve.

The VA has shown innovation in the past, for example, by recruiting nurses from Puerto Rico where there was an overage and bringing them to facilities in California. We hope that similar ideas are being explored now. The bottom line, the VA must be provided with sufficient funding with which to maintain an adequate pay schedule as well as other inducements for nurses and other health care professionals to remain competitive with the private sector.

Finally, the Congress must provide the VA with a budget sufficient to meet its obligation to provide the best modern health care to all eligible veterans in a timely and compassionate manner.

Thank you Mr. Chairman, this concludes my statement and I will be happy to respond to any questions you may have.

ADDENDUM TO THE

STATEMENT OF

DENNIS M. CULLINAN, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

WITH RESPECT TO

HEALTH CARE RESOURCES

WASHINGTON, D. C. SEPTEMBER 9, 1988

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

This addendum to the VFW testimony of September 9, 1988, is comprised of excerpts of VFW Reports of Survey conducted at various Veterans Administration Medical Centers throughout the nation by VFW Field Representatives. These excerpts will illustrate the severe problems now facing the VA's Department of Medicine and Surgery in providing for the health care needs of this nation's veterans because of inadequate funding. It is not the intension here to illustrate all the strenghts and/or weaknesses of the VA health care system, rather only to show in a clear and graphic manner that the integrity of the VA health care system is now threatened by budgetary shortfalls. Tragically, certain ill and disabled veterans are even now being deprived of the high quality and compassionate care which is their due.

VFW Report of Survey of the Prescott, Arizona, VAMC

July 25-28, 1988

The medical center is authorized 217 beds in the hospital plus a 214-bed Domociliary for a total bed capacity of 431...only 350 beds are open.

* * *

The operating budget for FY 88 is $21,556,700 which is about $140,000 above last fiscal year. This did not, however, keep pace with inflation. Expectations for FY 89 is for a decrease in funding.

* * *

The hospital has been grouped with Phoenix and Tucson for shared services. The Prescott Medical Center has a need for 50 CT scans per month. However, Phoenix can only provide 8 or less per month. This leaves the patients at Prescott without the services of this important diagnostic procedure since the center does not have the funds to contract for this service.

* * *

A meeting was held with all the Medical Service physicians to receive their views on the change of mission of the medical center. It was the general consensus that the practice of medicine at this medical center had been set back fifty years without the availability of surgery. The non-availability of surgical consultants to become involved early in the case, causes many concerns with the physicians.

Many of the medical test and procedures cannot be conducted without surgical back-up such as biopsy and endoscopies...

The lack of surgical back-up also has a serious impact on the intensive care unit as well as the respiratory technicians and nurses. Decisions by the health care provider can be adversly affected when they know that if any thing goes wrong, there is no Surgical Service back-up.

A hearing was held on July 5, 1988, by Senator Dennis DeConcini for the Senate Veterans' Affairs Committee, on the closing of the Surgical Service at this medical center. According to information received, testimony was given that this service had only performed 35 to 55 surgical procedures a year for the last 6 years...the annual reports from the Surgical Service for the last 10 years reveals that the number of operations far exceed the number given at the hearing for every year.

The following chart shows the number of procedures done during the last ten years:

FY YEAR	MAJOR	MINOR	DIAGNOSTIC PROCEDURES	TOTAL
1978	527	421	555	1,503
1979	474	468	544	1,486
1980	478	473	521	1,472
1981	439	409	477	1,325
1982	366	418	233	1,017
1983	364	365	250	979
1984	444	314	407	1,165
1985	340	329	454	1,123
1986	227	306	713	1,246
1987	10	607	424	1,041

* * *

This service [radiology] has a total of five rooms. There are four radiography rooms and one ultrasound room. Of these, three of the radiography rooms need to be replaced with new equipment. The head unit is over 25 years old. The tomographic unit is now due for replacement as it has reached its life expectancy and the radiographic/flurorscopy room reached this point over three years ago...

VFW Report of Survey of the Manchester, New Hampshire VAMC

July 19-22, 1988

The director has been on board for approximately five years. His major concern was the budget. The medical center is expected to have a million dollar plus shortfall in fiscal year 1989. With the high turnover rate in nursing service, overtime has cost the facility $6,000 per pay period. At the height of the overtime period, the medical center was expending $15,000 per pay period.

The Office of Management and Budget (OMB) initative presented to the Congress (1 percent productivity) has cost the medical center $245,000 which equates to seven Full Time Employee Equivalent (FTEE). In the last three years, this facility has lost 35 FTEEs.

* * *

Statistics by OMB indicates that the medical center should be able to do with $30,000 less because of the Decentralized Hospital Computer Program and the budget was so reduced.

The budget reductions experienced this fiscal year and scheduled reductions next fiscal year have and will continue without doubt seriously affecting the quality of care this VAMC can provide.

VFW Report of Survey of the Fort Howard, Maryland, VAMC

June 13-17, 1988

During our survey, we identified numerous deficiencies which required specific corrective action. Several deficiencies noted in our 1984 survey report have not been corrected. The physical plant is in drastic need of extensive renovations, especially the patient care areas. The rooms were very cramped and were not equipped with oxygen, air or suction. Patient privacy requirements were severely compromised throughout the facility, especially in the several 16-bed commune type rooms. The Nursing Home Care Unit is very crowded and the nursing stations are poorly located and not designed for patient observation. There are 11 unsafe quonset huts, which house several key clinical support functions, that are deteriorating rapidly. Several distinct fire and safety deficiencies were recognized which included insufficient sprinkler heads to respond to the problems associated with deadend corridors.

Management is totally aware of the serious problems that exist at this medical center. However, a higher level of support and funding is required to resolved this situation. We recommend Central Office authorize the funds to immediately activate construction projects which will modernize this facility as soon as possible. The need to correct the longstanding functional and space deficiencies that have been neglected at this facility over the past years is essential...

* * *

The current staffing ceiling of this [nursing] service is 163. However, there is a serious shortage of nursing staff. At this time of our survey, there were 27 RN vacancies within an authorized ceiling of 85 registered nurses. In addition, there were 23 LPN vacancies within a ceiling of 40 licensed practical nurses...

* * *

We asked if the VA medical center was still considered the preferred employer within the community and the response was NO. It was opined nursing salaries are very insufficient in this highly competitive market and special pay incentives are required to retain intermediate and senior pay grade nurses as well as initial and associate grade levels.

* * *

We noticed several radiology items listed on the District's unfunded equipment list. We were informed several pieces of equipment were beyond their replacement dates and were producing poor diagnostic images. The Ultrasound equipment was inoperative because replacement parts could not be obtained. The nuclear medicine equipment was outdated and constantly down for repairs. We recommend Central Office provide the funds required to modernize this clinical support service before it has further impact on patient care.

VFW Report of Survey of the Fort Lyon, Colorado, VAMC

May 16-20, 1988

This medical center has an average occupancy rate in the mid-90 percent range. This, when combined with the budget inadequacies and staff vacancies, is causing major challenges to the management skills of the hospital's leadership. Currently, the medical center is 25 to 30 short of the required staffing to adequately care for the veterans. A policy of limiting care to the nonservice-connected veterans has had to be placed in effect. To enable the hospital to maintain the number of employees they now have and still fund their mandated share of employee pay raises, it was necessary to divert monies from non-reoccuring and equipment funds to the salary account. This is creating problems in keeping the hospital running efficiently.

* * *

While the station equipment is in good condition, the loss of non-reoccurring funds may affect the continuation of this fact. The station has a new contract for the removal of their asbestos which was not correctly completed by the previous contractor. The station fire alarm system is piecemealed among the various buildings. A new system should be installed.

* * *

The current freeze on hiring support personnel is seriously affecting the ability of the health-care professionals to accomplish their mission. Many hours of hands on care by professional health care personnel are lost due to them having to accomplish the task of support personnel. This is the penny wise, pound-foolish situation found throughout the medical centers in the VA.

VFW Report of Survey of the Albuquerque, New Mexico, VAMC

April 18-22, 1988

This service [nursing] has an FTEE of 439.9. They are authorized 283.9 RNs with only 249.3 on board. Total vacancies number 53.6 with 19 being LPNs or nursing assistants. The turnover rate is running in the high 20 percent to low 30 percent range. There reasons given for leaving are for better working conditions, every other weekend off and better salaries.

* * *

This is one of the hardest hit [surgical] services by the current equipment budget shortages. They have 18 items on the station's equipment needs list which included drills and GU instruments. The service has 5 full-time surgeons and 19 residents. Last fiscal year, the service performed 2,098 major and 803 minor procedures, including 142 open heart surgeries. This fiscal year to date, they had completed 150 open heart surgeries.

* * *

...due to the medical center budget problems, prosthetics has been requested to reduce expenditures 10 percent for the remainder of the year. Since the budget for FY-88 was only $840,000, this would leave only $310,385 for the last 2 quarters. To meet this goal, supplies will have to be allowed to diminish and orders for prosthetic devices will have to be delayed. To assure that disabled veterans do not face the prospect of being unable to receive needed supplies and devices, supplemental funding will be required.

VFW Report of Survey of the Boston, Massachusetts, VAMC

March 21-25, 1988

...In reaction to the RAM, not unlike other facilities, this medical center initiated appropriate measures to "cut the fat". Compounded by stretching available staff as far as possible, this has resulted in an inability to adequately provide care to patients. While marginally staffed wards can manage the patients under normal conditions, the situation can be intolerable when the mix of patients includes many seriously ill.

* * *

This service [nursing] has a Full-Time Employee Equivalent (FTEE) of 311 Registered Nurses (RN), 88 Licensed Practical Nurses (LPN) and 125 Nursing Assistants (NA). There are 71.5 RN and 48.5LPN vacancies. As mentioned earlier in this report, there are 169 beds vacant that can be directly linked to the critical staff nursing shortages.

* * *

The last Admission Time Study was conducted during the week of February 1, 1988...Three hundred ninety-eight applicants were surveyed with an average admissions time of 3 hours and 17 minutes. This time definitely does not show admissions in a favorable light. The unavailability of admission beds and the desperate overcrowding conditions experienced in the ambulatory care area and throughtout the hospital contributes to the long admission times.

The occupancy rate dropped from 72 percent in FY 86 to 67 percent in FY 87. Wards closed due to nursing shortages do not decrease operating bed levels. These many only be adjusted with Centeral Office approval. Although the active wards had a generally high occupancy rate, those wards placed temporarily out of service helped cause the overall level to drop in comparison to FY 86. I find it difficult to understand that a medical center with an average occupancy rate of 58.3 percent is experiencing grave difficulties in admitting patients. Centeral Office should consider changing the way operating beds are accounted for.

* * *

The nursing shortage at this medical center must be considered as crucial. Numerous beds have been closed, resulting in critical problems for veterans requiring admission. Patients were observed on litters in the corridors of ambulatory care, waiting for beds to become available for admission. Non-urgent admissions are cancelled frequently to accommodate emergencies. The mechanism used by VACO to address nursing salary differentials, i.e., special rates, appears to be inherently designed to lag behind the community hospitals. Authority should be delegated to the Medical Center Director to address salary inequities for not only nurese, but also for other personnel shortages which are affecting the delivery of quality care.

It was reported that this medical center possibly has five-million dollars of unmet equipment needs. Many items have passed their life expectancy without being replaced. Fears are mounting regarding the inevitable day when diagnostic procedures cannot be performed, even if technicians are available. We request that Region become involved and responsive to these unmet needs.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
OF THE
SENATE COMMITTEE ON VETERANS AFFAIRS
September 9, 1988

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than one million members of the Disabled American Veterans and its Ladies' Auxiliary, I want you to know how very much we appreciate the opportunity to present our views regarding the current state of the Veterans Administration's Department of Medicine and Surgery (DM&S) and the adequacy of VA resources to meet current and future demands for VA health care.

Mr. Chairman, the subject of today's hearing -- which we simply define as critical underfunding of the VA's health care system -- is most timely.

Those of us -- and I believe there are many -- who do not see the system through rose-colored glasses or with tunnel-vision, are truly appreciative of the Committee's efforts to piece together a truly complex puzzle in a meaningful and understandable fashion.

With ever-increasing and alarming frequency, we are being contacted by veterans and our corps of National Service Officers (NSOs) describing restrictions in the type of care provided, denial of care and implementation of policies that can only be described as radical departures from the traditional VA health care delivery system.

Mr. Chairman, the DAV has recently completed two separate surveys of our National Service Officers representing our efforts to gain a sense of what is actually occurring in VA medical facilities across the country. The results of these surveys will be discussed later in my testimony.

As you are aware, Mr. Chairman, two years' ago, four veterans' service organizations -- AMVETS, DAV, Paralyzed Veterans of America and the Veterans of Foreign Wars -- joined forces to produce an Independent Budget for Veterans. Clearly, this exercise was born of our knowledge that funding of the Veterans Administration -- particularly DM&S -- was inadequate and, significantly more alarming, continuing on a downward spiral of erosion.

In our view, the funding deficiencies of DM&S are critical and progressively becoming more tenuous as concerns the future role the VA will play in the national health care delivery system.

Nearly six months' ago, a national conference call between VA Central Office and medical center directors revealed what could be interpreted as a poignant portrayal of the system.

At that time, VA medical center directors representing facilities as large and complex as Hines, Illinois, to rural hospitals like Miles City, Montana, and the Las Vegas, Nevada, Outpatient Clinic, painted clear, albeit dismal, common situations such as: management with no flexibility; drastically reduced and eroded funding levels; depleted equipment, maintenance and repair funds; employment freezes; workload reductions; operating deficits in the millions of dollars; concerns about quality patient care from a funding standpoint; inadequacy of the funding model (RAM); cancelling of facility projects; closures of entire wards; inability to implement new program initiatives; reductions of employees; changes in facility missions; concerns with medical school affiliations; and physician shortages.

Mr. Chairman, the continued erosion and decreasing real dollar budget available to individual VA medical centers and the resulting negative impact of the agency's mission is also a concern of many of the affiliated medical colleges working in partnership with the VA. We have learned of these concerns directly from deans of the various medical schools.

(As you are probably aware, Mr. Chairman, the Muskogee, Oklahoma, VA Medical Center affiliation with the Tulsa Medical College has effectively ceased.)

Two additional items we wish to briefly discuss are the draft versions of "Veterans Administration Department of Medicine and Surgery Fiscal Year 1989 Budget Problem Definition -- Options," dated July 6, 1988, and the "Chief Medical Director's Task Force Report on Fiscal Year 1989 Budget," dated July 28, 1988.

The first paper defines the budget problem as a projected Fiscal Year 1989 shortfall of $820 million based on known and potential budgetary requirements that exceed the current level of appropriations.

The second paper identifies a total of 86 options and recommends implementation of 17 specific options that have the potential to offset the projected Fiscal Year 1989 budget shortfalls.

Of all options presented, several deserve mention:

* Close medical centers
* Close Vet Centers
* Stop activation of newly constructed facilities
* Employee furloughs
* Do not implement Congressionally passed initiatives and program enhancements
* Drop prescription drugs for all outpatient care
* Restrict prosthetic services
* Eliminate the Chaplain Service

Mr. Chairman, what is abundantly clear from these documents is a large budgetary shortfall occurring in Fiscal Year 1989 and the agency's plans to counter this shortfall by dramatically eliminating, curtailing and denying VA health care services to eligible veterans.

It is interesting to note that nowhere in these papers -- or anywhere else -- has the VA set forth what appears to be a logical course of action, that being: an open, frank discussion to interested and competent authorities detailing the situation in meaningful terms with the goal being of maintaining the VA as a viable health care delivery service.

Mr. Chairman, the DAV has always held a keen interest regarding the VA's Prosthetic and Sensory Aids Service (P&SAS). Countless numbers of combat disabled service-connected veterans rely of P&SAS for devices and services that enable them to function on a day-to-day basis.

During Fiscal Year 1987 a VA-conducted survey found over 50% of all VA medical facilities reported delays in furnishing prosthetic services due to inadequate funding. Our best current information tends to indicate the situation has exacerbated in Fiscal Year 1988 and will continue to do so in Fiscal Year 1989.

Mr. Chairman, the $108 million funding level proposed for P&SAS in Fiscal Year 1989 will again prove to be insufficient in terms of an appropriate level of funding and the manner in which funds are allocated to field stations.

DM&S, as well as the Administrator, is aware of the situation, yet nothing occurs to remedy the problems. The VA's response to our concerns is to establish task force after task force with no substantial solution forthcoming.

Increased funding, to a level of approximately $120 million is part of the answer. An equal part rests with an allocation methodology of prosthetic dollars to the field that insures, to the greatest extent feasible, those dollars will be used to provide prosthetic services and not, as has apparently occurred in the past, be diverted for other purposes.

When reviewing and discussing the overall funding dilemma facing DM&S, we are hopeful the Committee will carefully scrutinize the entire funding process involving one of the most visible and certainly sustaining services within DM&S: Prosthetics and Sensory Aids.

Mr. Chairman, with the realization that inadequate funding exists, the DAV recently surveyed our National Service Offices attempting to learn the true magnitude of the situation.

NSOs were requested to provide documented evidence of situations occurring at VA health care facilities within their jurisdictions that, as a result of budget inadequacies, were producing restrictions, curtailments or other disruptions in the overall delivery of health care services to eligible disabled veterans.

We received responses from each of our 66 NSO offices located in every state, including the District of Columbia and Puerto Rico. Those responses were reviewed, analyzed and "Fact Sheets" were prepared detailing the situation specific to each facility on a state basis.

Mr. Chairman, we have provided each member of Congress with an appropriate "Fact Sheet" specific to the VA medical facility(ies) located within their state.

It is clearly evident that each facility is undergoing specific challenges and changes while attempting to continue to operate despite an inadequate budget. Obviously, some facilities are in worse shape than others, but all are realizing significant difficulties.

System-wide many common problems are readily apparent: bed closures; closures of entire wards; curtailing services and programs designed to treat eligible veterans; reducing or eliminating surgical procedures, especially elective surgeries; lack of funds to purchase, maintain or repair medical equipment; absurd waiting times for veterans to be seen for clinical appointments; forcing veterans to wait intolerable periods of time to be furnished prosthetic devices and supplies, or outright denial of these items; restricting and denying nursing home care; restricting the types and quantities of medications provided; excessive delays in filling prescriptions; deferring or eliminating construction projects; shortage of medical personnel, especially nurses; curtailment of outpatient services; inadequate safety standards; referral of veterans to other facilities, including private sources; closure of clinics to new patients; closures of satellite clinics; vacant positions not being filled; inadequate funds for drugs and medical supplies; and inadequate travel funds.

The list could go on and on.

The second endeavor undertaken by the DAV was a follow-up survey of our NSOs requesting specific information concerning individual veterans they may be aware of who have been denied appropriate VA medical care.

Mr. Chairman, to date we have received a number of responses to our request and we have provided the Committee a list of individual veteran's names and circumstances relating to the various types and degrees of denial of medical care.

Mr. Chairman, the DAV finds it almost incredulous that the VA health care system is in the current fiscal dilemma. However, we find it totally unconscionable -- based on the wealth of documented evidence -- that top-level management has continually maintained that there is no funding problem. Certainly, all of the accumulated documentation to date disputes the "we're O.K." rhetoric we are constantly barraged with. Clearly, our own information tears away at the flimsy fabric the agency is fond of draping over the system, attempting to disguise reality.

Mr. Chairman, if the VA is to remain a viable health care delivery service then two initial and crucial steps must be taken.

First, the agency must present the current state of the Department of Medicine and Surgery in a candid fashion regarding their present fiscal condition.

Secondly, Congress must be made aware of the current situation and come to a public policy decision regarding the future of the VA health care system. If the decision is the VA should remain and function as a vital ingredient to the national health care delivery system, then it is imperative that adequate funding be provided to enable the agency to carry out its mandated mission.

One final thought in closing, Mr. Chairman. The DAV wishes to extend our appreciation to the dedicated employees of the Veterans Administration who, faced with adversity over the years, have continued to create and implement creative management strategies in the field that have thus far tended to compensate for what has been at least a decade of decremental funding. Unfortunately, the reality of today is that there remains no more creativeness that will allow individual medical facilities to continue to provide an array of quality health care services. The resources have been stretched to, and sometimes beyond, acceptable limits. The only remaining option, absent an infusion of dollars, is wide-spread and sweeping vertical cuts in VA health care services. This is a situation none of us wish to witness.

Again, Mr. Chairman, the DAV wishes to applaud you and the Committee for your keen interest and staunch advocacy on behalf of this nation's disabled veterans.

This concludes my testimony and I would be pleased to respond to any questions you may have.

DAV

Motto: "If I cannot speak good of my comrade, I will not speak ill of him."

DISABLED AMERICAN VETERANS

NATIONAL SERVICE and LEGISLATIVE HEADQUARTERS
807 MAINE AVENUE, S.W.
WASHINGTON, D.C. 20024
(202) 554-3501

August 9, 1988

Honorable Alan Cranston
United States Senate
112 Hart Senate Office Building
Washington, DC 20510-0501

Dear Senator Cranston:

I am writing to alert you of the very real funding crisis facing the Veterans Administration.

This situation is of such severe proportions that virtually all VA medical facilities -- 172 VA medical centers, 117 VA nursing homes, 228 VA outpatient clinics and 17 VA domiciliaries -- are currently being forced to restrict or curtail a variety of medical services previously provided to eligible disabled veterans.

Additionally, VA regional offices -- charged with the delivery of earned benefits to disabled veterans, their dependents and survivors -- are faced with similar funding deficiencies resulting in veteran beneficiaries not receiving benefits they are entitled to in a timely and efficient manner.

The Disabled American Veterans has information revealing VA facilities in your state are experiencing specific problems as outlined on the enclosed Fact Sheet.

The enclosed clearly illustrates veterans are not receiving the VA services they are entitled to by law and by virtue of their honorable military service. All indications are the situation will get worse so long as the current level of funding for the VA remains unchanged.

Contrary to statements made by top level VA officials -- including the Administrator -- the Agency, particularly the Department of Medicine and Surgery, is faced with a significant budget shortfall for the remainder of Fiscal Year 1988. Internal VA documents suggest current year shortfalls approaching $120 million with a known and projected budget shortfall for Fiscal Year 1989 ranging from a low of $819 million to a high of one billion dollars.

System-wide, the Department of Medicine and Surgery is: operating fewer beds than mandated by law; curtailing services and programs to treat veterans; reducing or eliminating surgical procedures; lacking funds to purchase medical equipment or maintain and repair existing equipment; experiencing absurdly excessive waiting times for veterans to be seen and treated at certain clinics; forcing veterans to wait intolerable periods of time to be furnished prosthetic devices and supplies; restricting or denying nursing home care to veterans; restricting the type of medications furnished and experiencing excessive delays in filling prescriptions; and deferring or outright eliminating sorely needed medical facility construction projects. The list could go on and on.

Therefore, the purpose of this correspondence is: to make you aware of what is actually occurring within the VA health care system and the negative impact upon disabled veterans in your state and to request your support for urgently needed supplemental funding for the Department of Medicine and Surgery for the remainder of Fiscal Year 1988, as well as adequate and realistic funding levels for Fiscal Year 1989.

May we count on your active support?

Sincerely,

BILLY E. KIRBY
National Commander

BEK:am
Enclosure

FACT SHEET
STATE OF CALIFORNIA

Sepulveda VA Medical Center (VAMC):

1) "Several" wards have been closed for at least one (1) year.
2) Delays in scheduling appointments in the Eye and Cardiology clinics.

Long Beach, VA Medical Center:

1) No new patients are being placed in the Contract Community Nursing Home Program.
2) Certain service-connected disabled veterans have been removed from community nursing homes and admitted to VA operated nursing home units, imposing certain hardships upon family members' visits.
3) Appointments at certain clinics are unusually long with delays of up to eight (8) hours to be seen in the Primary Care Clinic.
4) Long waits at the Pharmacy with prescription refills limited to thirty (30) days.

Loma Linda, VA Medical Center:

1) Two (2) orthopedic wards have been closed.
2) New orthopedic appointments take from six (6) to nine (9) months before veteran is seen; "emergency" appointments take three (3) months.
3) Shortage of orthopedists.
4) Oncology clinic closed to certain veterans.
5) Prosthetics service is out of funds. (No artificial limbs, hearing aids, wheelchairs are able to be issued.)
6) Hospital is losing fifteen (15) full-time equivalent employees.
7) Clinic waiting times approach eight (8) hours.
8) Two (2) hour plus wait at Pharmacy.

Out-Patient Clinic, Los Angeles:

1) Unusually long delay in payment to private health care providers treating veterans.
2) Average of 173 day processing time to forward compensation and pension examinations to adjudicate disability claims.
3) Service-connected veterans have, on occasion, been billed for VA provided treatment.
4) Recruitment and training of health care providers are critical problem areas.

FACT SHEET
STATE OF CALIFORNIA
Page 2

West Los Angeles, VA Medical Center:

1) The Diagnosis Related Groups (DRG) Resource Allocation Model results in premature discharges from surgical service.
2) Allergy clinic open one-half day per week.
3) Long waits at Pharmacy.
4) Complaints of poor quality and cold food.

San Diego, VA Medical Center:

1) Ten (10) hour waits at Triage/Admission area.
2) Cardiac surgery has three (3) week backlog.
3) Two hundred and ninety-five (295) beds have been closed/never activated, due largely to lack of funds for staffing.
4) Certain veterans may not be enrolled as new outpatients.
5) High/complex care patients have difficulty securing nursing home care.
6) Generally one (1) to two (2) month wait for clinic scheduling with certain clinics; arthritis, cardiology, eye. Neurosurgery, longer waits.

San Francisco, VA Medical Center:

1) Two (2) wards closed due to staffing/budgetary problems.
2) Scheduled appointments have up to a three (3) hour wait to see doctor.
3) Retiring doctors are not being replaced.
4) Shortage of twenty-five (25) nurses with more anticipated.

Palo Alto, VA Medical Center:

1) One hundred forty (140) beds out of service.
2) Approximately eighty-seven (87) positions are vacant.
3) Approximate $10.3 million shortfall to bring nursing service staffing ratios equal to medical school affiliate (Stanford).
4) Agency imposed "productivity improvement" resulted in loss of seventy-four (74) employees and $1.7 million.
5) $1.9 million of equipment maintenance and repair funds will be spent for other purposes.
6) Inadequate funds of $200,000 for drugs, medical supplies and prosthetics.

Fresno, VA Medical Center:

1) No travel funds.
2) Nursing shortage.
3) Two (2) hour waiting time in clinics.

FACT SHEET
STATE OF CALIFORNIA
Page 3

Livermore, VA Medical Center:

1) Nursing shortage.
2) Excessive waiting time to be seen in Neurology clinic.

VA Regional Office, Los Angeles:

1) Considerable turnover of personnel.
2) Staff reduction of eight (8) full-time equivalent employees.
3) Long delays in processing of benefit claims.
4) Long delay in obtaining Vocational Rehabilitation Counseling (thirty workdays) from receipt of application.

VA Regional Office, San Diego:

1) Wait for Vocational Rehabilitation Counseling has recently doubled.
2) Delays encountered in providing needed supplies to Vocational Rehabilitation trainees.
3) Decreased training, supervision and guidance of Vocational Rehabilitation trainees.
4) Hiring freeze has resulted in most qualified individual sometimes not getting hired.

VA Regional Office, San Francisco:

1) Delays in adjudicating disability cases.
2) Delivery of services adversely affected based on reduction of employees.
3) Management -- Director, Assistant Director, Adjudication Officer, etc. -- spend time "filing."
4) Delays for Vocational Rehabilitation Counseling.

PVA
PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF
GORDON H. MANSFIELD, ASSOCIATE EXECUTIVE DIRECTOR
FOR GOVERNMENT RELATIONS
PARALYZED VETERANS OF AMERICA
BEFORE THE
OF THE
SENATE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
THE ADEQUACY OF VA HEALTH CARE RESOURCES
SEPTEMBER 9, 1988

Mr. Chairman, Paralyzed Veterans of America appreciates this opportunity to present our views on the status of the Veterans Administration's (VA) health care resources and the ability of the VA to maintain the quality and quantity of care veterans of this nation require.

Mr. Chairman, in our opinion the VA health care system is in deep trouble. Years of budget shortfalls have cut into the bone of the system's ability to maintain bed levels, staffing levels, and timeliness in the provision of essential medical services.

Veterans are being denied access to quality health care.

Medical services are being rationed based on the availability of resources - medical equipment, supplies, pharmaceutical and prosthetics.

The VA cannot continue to meet the increasing needs of older and disabled veterans unless significant resources are applied to meet obligated service levels mandated by the Congress.

From a fiscal standpoint, the average VA medical center is eating itself alive. It is cannibalizing existing resources for building maintenance, repair, modern medical equipment, essential medical services and restricting and denying access to medical care for eligible veterans in order to meet yearly major deficits in operating funds.

VA Administrator Thomas Turnage appeared before PVA's Annual Convention in Chicago, Illinois, on August 24, 1988. He stated the following:

> (This Administration) has done more, contrary to what critics say, to improve and enhance veterans' benefits and services than any Administration since the last soldiers returned home from the Second World War. Even in today's environment of bipartisan efforts to cut federal spending, VA's budget, workforce and physical plant are all larger than they have ever been . . . He went on to say, "In spite of all that's been accomplished, there are still those who want to criticize. Their answer to all of the alleged shortages is always more money, more resources."

Mr. Chairman, I believe it safe to say that VA budgets over the past eight years would have been an utter disaster if the Congress, in a bipartisan effort, hadn't bailed the VA out by restoring certain funds to yearly proposed Administration budgets. Over the years, OMB has shown no interest, concern or respect for the needs of the VA medical system. Their budget analysts have deliberately set the VA adrift. We must make certain that the system is set back on course.

Over the past several years, the Administrator, as well, has demonstrated either a careless disregard for the facts or a total unwillingness to accept the truth from his own subordinates as to the ability of the VA to perform its mandated mission. If you look at the ledger sheets, it sure sounds good to say that VA budgets have increased since 1945 - they sure have - but so have the complexity and expense of modern medicine and the increasing needs of aging and disabled veterans.

Even with the funds restored by Congress over the past several years, the VA health care system is strapped. Thousands of useable hospital beds have been taken out of service due to the lack of nurses and support staff. Eligible veteran patients are being denied care. Surgery, medical treatment, prescriptions, and prosthetics are being rationed and delayed in a desperate attempt by medical center directors to overcome operating shortfalls that, in many instances, run into 7 figures each year.

A sign which appeared last month at the San Diego, California, VAMC outpatient clinic is a clear example of what the present and future hold for the VA.

> ATTENTION: EFFECTIVE MONDAY, AUGUST 15, 1988, PATIENTS REQUIRING URGENT OR UNSCHEDULED CARE WILL NOT BE SEEN AT THIS FACILITY. THOSE PATIENTS SHOULD REPORT TO THE ADMISSION/TRIAGE AREA AT THE VETERANS ADMINISTRATION MEDICAL CENTER, 3350 LA JOLLA VILLAGE DRIVE. (Attachment A)

Administrator Turnage was quoted in The Washington Post on August 31, 1988, saying:

> We may not get what we want, but we get all we need to do our job well. Anyone who tells you we're not well-funded - well - I think they are whistling 'Dixie.'

Well, listen to what no less authority than the Administrator's own Chief Medical Director, Dr. John Gronvall, had to say about the adequacy of VA health care resources during hearings held by this Committee on July 14, 1988.

> I have just had a chance to review the past 10 years of data about the whole VA health care system. Without getting into too much detail, during that time, if you adjust our appropriation on the basis of medical care CPI, our funding has been level. During that time, we have significantly expanded the number of patients treated in our hospitals. We have significantly expanded the number of patients that we pay for in other hospitals. We have opened new nursing homes and significantly increased nursing home census - and we have amazingly expanded the extent of outpatient care going from 5 million visits a year to 20 million visits a year. All of that has been accomplished with an appropriation that is level in terms of purchasing power. That has been done by a whole set, I think, of very strong internal dynamics that put pressure on increased productivity and the accomplishment of new programs without real resources - and that has come about by reallocation from existing or previously existing programs ... All the information we have about the coming year, 1989, is even more bleak than the past ten years.

Mr. Chairman, that tune does not sound like "Dixie" to me. This statement sounds to me like a cry for help from a health care system in serious financial straights. This is the same cry for help that we have documented from an informal survey of VA medical centers conducted by PVA's National Service Officers over the past three weeks. The data ootained in this survey which we will present to this Committee separately paints a picture of a health care system which is being financially strangled. Quite frankly, Mr. Chairman, it is astounding that, for whatever reason, the VA Administrator is not willing, or able, to understand what his own medical managers are experiencing in the field and in Washington.

Part of this problem could come too from a situation where management in the VA has become so decentralized that individual VAMC's have been set adrift and have become far too removed from proper central office administration and oversight. Some of this decentralization is due to intentional administrative reorganization, but a great deal of it is due to lack of resources as well.

At the same Senate hearing on July 14, 1988, Dr. Gronvall was asked about the Department of Medicine and Surgery's efforts to monitor adequate quality assurance standards and review on-going in-patient treatment programs for Vietnam veterans at several VAMC's. His response was directed to the existing inadequacy of current VA Central Office programs as a whole designed to monitor health care quality assurance system-wide.

"In the whole range of other review activities, where in the past we have made commitments for some schedule of Central Office review of programs, we have found that those commitments have been impossible to keep. The Central Office appropriation, in the past couple of years, has been cut back about 25 percent. So, we have had a reduction in staff, and in travel and support.

Again, as recently as August 24, Dr. Gronvall and his staff met with PVA representatives and representatives of other veterans' services organizations here in Washington. He told us then, quite simply, using his own words:

> "DM&S has serious budget problems."

Dr. Gronvall also outlined a series of proposals which have been recommended to him by his staff which he hopes to implement October 1, 1988, in order to meet budget shortfalls. These measures include:

1. DM&S will not take funds off the top of the FY'89 appropriation to fund new initiatives.
2. Will defer programs to fund the acquisition of new high tech equipment.
3. Will defer program to purchase "joint venture" equipment, i.e., equipment purchased jointly with affiliated medical schools.
4. Eliminate contract support for organ transplants -- will be done in-house and will be limited to Category A patients.
5. Establish a system of controlling quantity of medical care in order not to compromise quality of care. Eligibility will be defined by statute. There will be equity of access to services on geographical basis.
6. Decentralize management of non-VA accounts - local VAMC's will control.
7. Freeze nonrecurring maintenance funds.
8. Terminate program of over-the-counter (OTC) drugs when veteran (discretionary) is being seen on outpatient basis only. Terminate prescription drugs for discretionary veterans (Category C). In this case, the VA would write the prescription and veteran would pay VA or take prescription to outside pharmacist.
9. Do not fully implement some of the discretionary provisions of P.L. 100-322, i.e., beneficiary travel. It will cost $50 million to fully expand beneficiary travel. FY'89 appropriations do not cover

this. Other services would have to suffer if fully implemented. Ambulance travel, special mode transportation, and volunteer services would be sufficient to accommodate beneficiary travel.

Mr. Chairman all of these proposals will have a most serious effect on veteran patients in need of health care service. But one specific example comes to mind to bring this situation down to terms of basic human need. The Chief Medical Director stated that the availability of over-the-counter drugs and prescriptions and medical supplies would have to be curtailed for certain veterans.

For many catastrophically disabled veterans this would have disastrous consequences for their daily health maintenance. Included on the list of such over-the-counter items are bed-side drainage bags, gauze sponges, urinary pouches, rubber gloves, suppositories, paper tape, equipment and supplies for personal daily hygiene. Certain VAMCs are already refusing to provide these items. Attached is a memorandum from the Denver VAMC detailing restricted over-the-counter items at that facility. (Attachment B)

This is, Mr. Chairman, not the only example of how a shortage of funds for pharmaceuticals and staff VA pharmacists are causing cutbacks and disruptions in services, even for service-connected disabled veterans. PVA National Service Officer in Detroit, Michigan reports:

> About a year ago, the Ann Arbor VAMC announced a policy change whereby Pharmacies would no longer refill outpatient prescriptions. All refills would be processed through the Toledo, Ohio, Outpatient Clinic approximately 50 miles away. This policy change was necessary because of staffing shortages and high workload in Pharmacy Service.

> When I learned of this policy change, I met with the Chief of Pharmacy over the impact this change might have on the severely disabled veteran. The Chief of Pharmacy informed me any emergency prescription would be refilled at the Pharmacy in Ann Arbor.
>
> In March 1988, Ms. Judy Ross, who is service-connected for blindness, paraplegia and a seizure disorder secondary to MS, reported to the Outpatient Pharmacy to obtain medication for her seizure disorder. The Outpatient Pharmacy refused to refill the veteran's prescription and was told all refills are processed in Toledo.
>
> As recently as June 1988 at the monthly service officers' meeting, I again expressed my concern regarding Pharmacy Service not filling emergency prescriptions at the window. To date (August '88) no reply has been received.

The PVA survey, designed for this testimony, received responses from over 100 of the VA's 172 medical facilities. Needless to say, considering internal VA organizational pressures, some medical centers were more forthright in commenting on their current condition than others. However, we would like to publicly express our appreciation to all of these medical center directors and their staff who cooperated so well with our request for information. They are on the front line of VA health care delivery serving veterans every day. We hope that this Committee would ensure that their candor in providing this information for the benefit of the Congress is fully protected. These men and women work very hard every day with what resources are made available to them, for the benefit of our nation's veterans. We are very grateful for their help and support.

To begin, Mr. Chairman, PVA understands that a Task Force has been appointed by the Chief Medical Director to review the Department of Medicine and Surgery's budget for the next fiscal year. The report predicts a Fiscal Year 1989 operating shortfall of well over $800 million. We believe this figure, while intolerable, to be a low estimate. Present projected shortfalls do not fully account for the decremental budgets passed on as "current services" figures. This eroded base-line has compounded the budget shortfall incrementally from one year to the next for the past eight years. Projected deficits do not even come close to addressing the actual needs of the system for research modern medical equipment and maintenance and repair funds.

Estimates contained in "The Independent Budget for the Veterans Administration" published earlier this year by four veterans' service organizations, including PVA, indicated that the system has up to a one billion dollar backlog in the purchase and acquisition of up-to-date medical equipment. Equipment and facility maintenance and modernization funds notoriously have been short changed in VA budget requests.

Historically, those funds are cannibalized to cover larger deficits in medical center operations and direct medical care. This activity has gone on uncontrollably for years in the VA. In the process, the agency has been "eating its own seed corn."

The inability of a medical center to maintain or replace equipment in accordance with new, albeit expensive, medical technology, presents both a direct threat to the quality of the health care provided and even higher costs when those services and procedures have to be contracted out to non-VA facilities. To cite just one example, we have been told that the fluoroscopy equipment at the West Haven, CT, VAMC was emitting, or leaking, uncontrollably high levels of radiation when in higher power use. No funds to replace the equipment were available at the time. As a temporary solution, the facility decided to fluoroscope only thin veterans at low power. Veterans with higher body weight were sent to the affiliated non-VA hospital for fluoroscopy to avoid the possibility of excess radiation exposure. Fortunately, this unit has been shut down entirely, but not replaced.

Mr. Chairman, as stated previously, we have presented the entire results of our survey to the Committee for your review. However, within the context of this testimony there are certain specific items we would like to present as examples which underscore the difficulties currently experienced in the VA health care system. From the start, this material makes clear that eligible veterans are being denied access to VA health care services.

- Attached for your review is a sample letter sent to a veteran from the Salem, Virginia, VAMC, denying care to that veteran and stating that certain treatment is restricted only to service-connected disabled veterans. This would appear to be a complete abrogation of eligibility standards established in P.L. 99-272 and P.L. 100-322. (Attachment C)
- On April 7, 1988, the San Diego VA Medical Center Daily Bulletin advised its readers that .... "effective Monday, April 11, 1988, this Medical Center (to include the Mission Valley Outpatient Clinic) will begin to discontinue the provision of service to veterans in eligibility category C. This discontinuation of service is due to a decline in the availability of resources. Medical Administration Service (MAS) will be developing the implementation plan for the change, and they will be disseminating this information to the staff. It is important to remember during this process of curtailment that it is MAS who will make the eligibility determination and advise the veterans. All veterans will receive an evaluation to determine the urgency of medical care required; however, not all veterans will be entitled to the recommended future care. This will be a difficult time for all of us, but more importantly for those veterans who will be informed that they will not be able to receive care." (Attachment D)
- Letter of denial of care for Category C veterans at the San Diego, CA, VAMC. (Attachment E)

- On August 5, 1988, the Director of VAMC, Reno, NV, announced an approximately $2 million reduction in FY'89 funding for this medical facility. (Attachment F)

- On June 29, 1988, the Chief of Staff and Acting Director at Reno, NV, VAMC sent a letter to a local ambulance service requesting that the company " ... avoid bringing patients with SUSPECTED CARDIAC ISCHEMIA to the Reno VA Medical Center, effective immediately. This Medical Center has no staff cardiologist and is unable to provide prompt and appropriate care for such patients." (Attachment G)

- On April 18, 1988, VAMC Seattle was forced to limit access to several outpatient clinics to "new veterans with optional eligibility (priorities IV to X) in order to constrain workload within available funding." In addition, the medical center has twenty-six clinics which are closed to nonservice-connected veterans. (See attachment H for clinics closed to Category B and C veterans.)

- As a result of inadequate funding, VAMC San Francisco reports that they have suffered RAM losses totaling over $4 million from their recurring base the past four years. Unfunded expenses for the care of AIDS patients is $5 million for FY88 and $8 million (projected) for FY89. This situation reached such proportions that in June of '88 the VA Regional Director for the Western VA Region sent an urgent appeal to other VA medical centers in the Region to ask them to "loan" the San Francisco VAMC resources from their own accounts just to bail San Francisco out until the end of this year. (Attachment I)

- VAMC Richmond shows FY88 unfunded operating expenses of $2,570,008. Referrals of Category C veterans requiring services have been restricted due to current workload demands.

- VAMC Buffalo, N.Y., reports a total of $1,267,083 of unfunded operating expenses for FY88.

- VAMC Long Beach, CA, reports unfunded operating expenses well in excess of $2.5 million.

- PVA's Chapter, Eastern Paralyzed Veterans Association (EPVA), this summer, conducted a survey of inpatients at spinal cord injury centers at three VA Medical Centers in their geographical area - Castle Point, N.Y. VAMC; Bronx, N.Y. VAMC; and East Orange, N.J. VAMC. Copies of the results of this survey have already been given to this Committee. In summary, the study showed increasing dissatisfaction among patients and staff with the amount and degree of care being given at these facilities. Bed and staffing reduction are tied directly to shortfalls in resources.

In response to the survey, the Associate Director at Castle Point VAMC wrote the following statements in a letter to EPVA Executive Director James J. Peters, clearly signalling his severe frustration with the lack of funds available to maintain current levels of care.

...."Due to staffing shortages in nursing, we were compelled to reduce our actual operating beds to 196 which we believe matched our staffing levels to ensure safe and adequate patient care. Although we have received approval of special salary rates for nurses and LPN's, there has been no impact relative to our ability to recruit new staff .....

The result of the resource allocation model indicates we will be reduced by at least $485,000.00 in FY89. Our supply costs (i.e., Pharmacy ward stock, etc.) increased by more than $800,000.00 in FY88 over FY87 and our Services are requesting significant increases beyond our expenditure rate in FY88 and FY89 . . .

. . . (Mr. Peters) the last paragraph of your letter says it best - 'The excuses of - we cannot hire staff, we don't have money, staff is not available are no longer valid.' I regret that our excuses must in all reality be accepted as fact." (The full text of this letter appears as Attachment J.)

- VAMC Kansas City, MO, reports: "Many of our outpatient clinics are overbooked so the next available appointment ranges from less than two weeks (September 6 for Neurology screening) to over four months (January 6 for General Medicine). Average waiting time is about two months. So, while there is no policy to delay treatment, the overload in clinics does, in fact, result in delay."

- VAMC Boise, Idaho, reports: "VAMC Admission Waiting lists: average waiting time for nonemergency clinic General Medicine - 3.5 months, General Surgery - 1 month, Ortho - 4 months, Ophthalmology - 3 months, Cardiology - 2 months, Urology - 1.5 months, Mental Hygiene - 2 months, Substance Abuse - 1 week. Ortho, Ophthalmology and Cardiology are being restricted to service-connected and Category A."

- VAMC Sepulveda, CA, states that they have not had to turn away any nonservice-connected veterans; however, they report unfunded operating expenses of $2,274,389 for FY88.

- VAMC Jackson, MS, reports FY88 unfunded operating expenses totalling $941,183.

- VAMC Gainesville, FL, reports FY88 unfunded operating expenses totalling $2,127,971.

- In addition to FY88 unfunded operating expenses of $1,286,668, VAMC Bay Pines, FL, reports that due to demand, treatment for nonservice-connected (Category B) veterans is not reasonably available in the following clinics: Allergy, Cardiology, Dermatology, Diabetes, Endocrine, ENT, General Medicine, GYN, Hypertension/Renal, Neurology, Obesity, Ophthalmology, Optometry, Orthopedic, Podiatry/Amb. Surgery, Pulmonary, Rheumatology, and Urology.

- VAMC Nashville reports an FY88 shortfall totalling $1,971,115.
- VAMC Murfreesboro, TN, reports FY88 unfunded operating expenses totalling $1,888,067.
- VAMC Augusta, GA reports FY88 unfunded operating expenses totalling $1,639,940.

Shortages of Registered Nurses in the VA

Mr. Chairman, as we stated previously, PVA's Department of Veterans' Benefits sent informal surveys to National Service Officers (NSO's) in the field. Most of the responses we received were a reflection of information provided by Medical Directors at various stations across the country. The survey, although not meant to be scientific in nature, did strongly support the presence of a severe nursing shortage in the VA. We asked the NSO's to report the number of RN's per number of operating beds for both the VA and a private-sector hospitals in the area.

In most instances, the number of RN's per bed in the private sector far exceeded the rate in VA hospitals. The shortage of RN's forces the VA to rely more heavily on LPN's and ancillary health personnel to staff its hospitals. But even that base is eroding. Recruitment and retention remains a serious problem. The number of RN's currently authorized by the VA is minimal at best, but basic policy is even more difficult to track since the Agency has yet to formulate and promulgate staffing guidelines. Without sound and comprehensive staffing guidelines, the VA has insulated itself behind an impenetrable wall of variables and as all veterans know, there is nothing more formidable than in invisible enemy.

John Fears, Director of VAMC Hines, Chicago, Illinois, offers the following perspective on the VA nursing shortage in response to our survey:

> "A current American Hospital Association (AHA) survey (1987) indicates that in private sector Illinois hospitals, the average registered nursing hours per patient day is 5.95 for medicine and surgery combined. VA Hines' average is 2.48 nursing hours/patient day for medicine and surgery (based on RN FTEE of 186.6 and ADC of 364 for medicine and surgery combined). Thus, patients in private-sector hospitals receive more than two times the amount of nursing care than they would receive in a VA hospital. This is true not only because we have fewer nurses, but because the nurses we do have out on the wards are spending more and more time doing non-patient types of activities; activities such as inputting data and orders into DHCP, patient escort, picking up supplies from SPD, bed cleaning, emptying trash, taking specimens to the lab, etc.
>
> Cut-throat competition exists throughout the Chicago area for recruitment of nurses. The VA is not at all competitive due to its cumbersome method of requesting special salary rates. Of the 400 GNT's we trained last year, one accepted a position here. The others refused, indicating that there are too few nurses on the ward, not enough support staff and low pay.
>
> The obvious question then becomes: why are the nurses spending more time doing non-hands-on types of activities? Because the ancillary support staffing levels are not what they should be, according to VACO standards. For example, based on the Manpower Planning Division Staffing Report for the first quarter FY 1988, "earned FTEE" levels exceeded "actual FTEE" levels in Building Management (Sanitation: 246.99 vs. 175.50); Clinical Lab (152.90 vs. 117.40); Medical Administration (296.16 vs. 269.38); Pharmacy (99.89 vs. 88.73); Rehabilitation Medicine (60.74 vs. 57.21); and Social Work (55.14 vs. 51.94). Historically, these support services have demonstrated a percentage of effectiveness (earned FTEE/actual FTEE x 100) well in excess of 100%. This means that we're doing more with less, and the nurses up on the wards are having to cover where our shortages are. Based on the few services which this report calculates "earned vs. actual", VAH Hines "earned" 101 more FTEE than we have. This equates to $3,434,000 more in salary dollars which we "earned" but which are not forthcoming.
>
> In the article "As Margins Fall, Executives Forge Survival Tools," Hospitals, March 20, 1988, pp. 48-52, a comparison was made regarding staffing levels and number of beds in the private sector. Using their methodology, we extrapolated what our FTEE per occupied

bed percentage would be (please refer to enclosed graph). According to this article, private sector hospitals of 500 beds or greater have 5.16 FTEE per occupied bed. VA Hines has 3.01 FTEE per occupied bed. In order for us to match the private-sector standard, we would require an additional 2,214 FTEE, and approximately $77,000,000 in salary dollars." (Attachment K)

- When asked to compare VA RN staffing with private-sector hospitals in the area VAMC Seattle responded: "We operate at the lowest RN to bed ratio and the lowest RN to patient ratio in the Seattle medical area."

The results of our informal survey regarding RN vacancies are as follows:

Region 1:

VAMC	RN Vacancies
1	0
2	23
3	unspecified but report 114 beds out of service due to workload reduction
4	0
5	0
6	60 (includes all nursing personnel)
7	25
8	unspecified
(3 responses) Total	108

Region 2: Data collected on 19 VAMC's as follows:

VAMC	RN Vacancies
1	50.5
2	0
3	29
4	28.5
5	30.1
6	5
7	43
8	7.7
9	6 (Experienced 30-40 FTE nurse reductions in FY 86)
10	13.6
11	10
12	3
13	1
14	3
15	3
16	10
17	1

18		2
19		12
	Total	258.4 (19 responses)

Region 3: Data collected on 16 VAMC's as follows:

VAMC		RN Vacancies
1		28
2		9
3		28
4		4
5		5
6		24
7		34
8		13.6
9		12
10		34
11		1
12		0
13		26
14		12.3
15		16
16		25 (as of 6/30/88) 54 (as of 8/13/88)
	Total	300.9 (16 responses)

Region 4: Data collected on 14 VAMC's as follows:

VAMC		RN Vacancies
1		26.4
2		27
3		21
4		31.3 (with reduction of 34 beds)
5		unspecified
6		35
7		2
8		29
9		38
10		4
11		0
12		12
13		28.1
	Total	253.8 (12 responses)

Region 5: Data collected on 19 VAMC's as follows:

VAMC	RN Vacancies
1	10
2	2.9
3	17

4	unspecified
5	2
6	unspecified
7	13
8	5
9	24
10	1.7
11	unspecified
12	10
13	28
14	3
15	0
16	1
17	9
18	7
19	23.5
Total	157.1 (13 responses)

Region 6: Data was collected on 13 VAMC's as follows:

VAMC	RN Vacancies
1	43
2	48
3	17
4	72
5	17
6	42
7	6
8	0
9	9
10	listed as "none due to budget constraints"
11	10
12	11
13	20
Total	295 (13 responses)

Region 7: Data collected from 14 VAMC's as follows:

VAMC	RN Vacancies
1	10 "staffing for beds" 60 "staffing for patients" VAMC reports 15
2	15
3	unspecified but verified shortage
4	unspecified but verified shortage
5	25
6	0
7	0
8	unspecified but verified difficulty
9	unspecified "There are no staff shortages because of Budget"
10	0

11	17.3	
12	5	
13	15	
14	0	
Total	92.3	(10 responses)

In summary Mr. Chairman, PVA's service officers surveyed over 100 VAMCs. Of these, 89 VAMCs gave responses (or the NSO was able to obtain responses) to which numerical value could be assigned for numbers of existing RN vacancies.

In total, with just over one-half of the 172 VA medical centers reporting our informal survey reveals a total of more than 1,465.5 RN vacancies. In reality its most likely much, much more. Given the fact that RN to patient and RN to bed ratios are already considered low even when VAMC's have filled all authorized positions, the RN shortage in the VA is indicative of a quality of care problem which directly affects hospitalized veterans. Some may counter this argument by saying that nursing shortages are a national problem these days common to all health care systems, private and public. That is true. But the VA is not equipped either financially or administratively to respond and compete on an equal basis within the context of this national nursing shortage with the rest of the national health care sector.

PVA respectfully submits, Mr. Chairman, that denial of care comes in many forms. When a veteran calls for a nurse and one is not available...that is denial of care. When a hospital admission or surgical procedure is delayed because of inadequate staffing or bed closures, that too is denial of care.

Prosthetics

Mr. Chairman, also included in our informal survey were questions regarding the budget and funding of prosthetic equipment and supplies.

The provision of prosthetics to disabled veterans has been a long-time concern of PVA. Prosthetics, orthotics and other medical devices include items such as wheelchairs, leg braces, crutches, artificial limbs, lifting equipment and bathroom assistive devices. For PVA's members, as well as other severely injured veterans, the use of these devices can make the difference between living as normal a life as possible and remaining housebound or bed-ridden. For disabled individuals, prothetics are not options, they are requirements for quality of life. The delay in delivery of adequate and appropriate devices has a direct affect on the veteran for each day he or she is without these assistive devices.

PVA emphasized the importance of this issue at the House Committee on Veterans' Affairs hearing on the VA Budget on March 3, 1988. At that time, we identified a growing problem in the intentional delay in the provision of prosthetic devices and appliances which are so vital to the rehabilitation of disabled veterans. As a result of an analysis of an inquiry PVA directed to our service officers in the field at that time, we were able to provide the Committee with concrete examples that, in many instances, it takes weeks and months for an application to be filled and even then, the equipment provided is often times substandard, make-shift, outdated or inappropriate. The problem can be directly traced to the lack of clear identification within the budget allocation of each VA medical center for a specific line item which can designate funding levels for prosthetics and prosthetics only. The problem can be resolved if such a line item is designed and adhered to by VA central office direction and individual VA medical center disbursement policies. But, most important, the problem can be resolved if sufficient resources are given to each VA medical center to meet the prosthetic needs of that station.

As it stands now, the yearly prosthetics funding allocation for each VA medical center is unspecified within its budget for that purpose and lumped into the general medical care allocation. As the demand and cost of VA health care rise, the dollars to provide that care continue to shrink. An individual medical center director, under these circumstances, is increasingly tempted to "borrow" or transfer funds which should be used for prosthetics to pay for other services. We believe this to be a common and condoned practice in the VA system today and our most recent survey verified this belief.

Shifting funds from general prosthetics needs, quarter by quarter during any given fiscal year, a medical center director can only compensate for the shortfall by delaying the provision or purchase of prosthetic equipment. If funding for prosthetics has run dry in a given quarter because a sizeable portion of the full allocation was shifted to other purposes, an application for a wheelchair, for instance, for an eligible veteran very often might have to wait until well into the next or subsequent quarter until the new quarterly allocation takes care of the pending backlog of prosthetic requests from previous quarters and sufficient funds are available to cover the cost of that wheelchair. In the meantime, as is happening in many cases, the veteran is furnished substandard, inappropriate or ill-fitting used equipment when funding is not available to provide new devices. Both the VA and the veteran suffer extreme inconvenience, particularly in the provision of state-of-the-art high tech equipment. Such equipment is mandatory for the rehabilitation needs and quality of life of disabled veterans.

When we reanalyzed the situation regarding prosthetics in preparation for today's hearing we can only conclude that these circumstances have not improved. In fact, in many instances, the situation has become far worse as we near the end of the fiscal year.

Again, Mr. Chairman, Administrator Turnage has said:

> We may not get all we want, but we get all we need to do our job well...

Mr. Chairman, the reports from the field indicate that not only are veterans unable to get what they want, a whole lot of them are not even getting what they need.

PVA offers a West Roxbury-Brockton VAMC memorandum as evidence of the compromised service veterans, in need of prosthetics, must endure. The memo is dated May 12, 1988, and we would like to specifically call your attention to item #5 which reads in part: (Attachment L)

> There are many items which will have to be delayed until July, and some which may have to be delayed until October. We are working with very limited resources. Please be as conservative as possible in prescribing equipment. Something provided for one veteran will mean that another may have to do without."

Mr. Chairman, there are veterans who are not getting what they need. Delay is a form of denial.

PVA will now provide a sampling of comments from our survey regarding prosthetic funding from across the country.

Region 1:

VAMC West Roxbury (Medical Director comment)

"We have reduced our prosthetic stock inventory by $30,000. There are pending requests amounting to $23,000 for which we have $10,000 remaining in the account for the remainder of the year..."

VAMC Batavia (NSO comment)

" Director states there are no back orders or backlogged time elements or funding shortage. However, in a conversation with the Chief of Staff on the National Service Officer's visit of August 2, 1988, the Chief was concerned over the fact that they did not have enough funds for the Prosthetics Department. The Director painted a nice picture, but the word around the medical center is that there are shortages in Prosthetics, Pharmacy and Nursing."

Region 2

VAMC Washington,D.C. (Medical Director comment)

"Funding shortages for Prosthetics Service amount to $120,000."

VAMC Richmond (Medical Center Director comment)

"As of August 19, 1988, 77 prosthetic orders, a total of $90,014, have been prepared and placed on hold because of budget constraints. Funding for the remainder of the year stands at $31,914. Orders on hold are being processed on a priority basis."

VAMC Butler (Medical Director comment)

"The amount of backlogged orders will be approximately $27,000 during the fiscal year."

VAMC Huntington (Medical Director comment)

"There are no order backlogs but prosthetics will exceed the allocated budget for FY 88 by approximately $40,000."

Region 3

VAMC Gainesville (Medical Director comment)

"There are no prosthetic orders delayed at this time because of a local funding shortage. However, due to increased nondiscretionary workload and a budget shortfall, it has become necessary to apply eligibility and medical criteria more rigidly prior to procurement of major medical equipment/ prosthetics. Should additional budgetary erosion occur in FY 89, it will be necessary to further restrict delivery of not only prosthetic items, but other direct medical care services in various outpatient care programs. As an example, the estimated dollar amount of reduction in inventories for drugs, medical supplies, and prosthetics as a result of inadequate funds in this fiscal year is $650,000."

VAMC Bay Pines (Medical Director comment)

"We estimate there is a shortage of $450,000 for FY 89 in the Prosthetics Service for this Medical Center..."

VAMC Nashville (NSO Comment)

"Prosthetic Funding Shortages -$188,000-6 weeks, 60 orders backlogged."

VAMC Memphis (NSO comment)

"I contacted _________, Prosthetics Chief, and was told that there are no backlog orders, only shipping delays. They are having budgeting problems on a continual basis. For the entire fiscal year, they have been obligating the next quarter funds when they exhausted the current quarter funds. Therefore, as we come to the close of the fiscal year they are currently $250,000 in the red. They will carry this over to next year's budget within one week of the fiscal year 1989. Due to the shortage of funds there are limited prosthetics on hand."

Region 4

VAMC Allen Park (Chief of Prosthetics comment)

"Additional funds of $150,000 for FCP 092 were requested in writing on August 2, 1988 and an additional $40,000 was transferred to FCP 092 to procure prosthetic appliances."

VAMC Indianapolis (NSO comment)

"The prosthetic account had to be augmented by $442,000 from reprogrammed equipment and maintenance accounts."

VAMC Cincinnati (Medical Director comment)

Prosthetics funding: "A current shortage of $71,700 exists as of August 25, 1988, with a back log of 222 orders of which the oldest order is 69 working days old."

Region 5

VAMC Columbia (Medical Director comment)

"We have identified an unfunded need of $190,000 in prosthetic funding for FY 1988."

VAMC Kansas City (Medical Director comment)

"There are currently some shortages in prosthetics. Some of these shortages will be covered with funds currently being received from VACO and Region."

VAMC St. Louis (Medical Director comment)

"Due to budget restraints, approximately $205,000.00 in third quarter orders were carried over for purchase in the fourth quarter. It is estimated that $200,000.00 is needed to meet orders expected through the remainder of this fiscal year."

VAMC Wichita (Medical Director comment)

"Current backlog amounts to $47,000. Purchases are pending additional funding on October 1, 1988."

Region 6

VAMC Loma Linda (Medical Director comment)

"A spot survey shows 592 prosthetic orders pending. A constraint of two orders per day (for emergent cases) is placed on order processing due to lack of funds. Our average delay in placing orders is six weeks. Generally, prosthetics is funded $600,000/year but requires $850,000 to fill eligible requests."

VAMC Martinez (Medical Director comment)

"$100,000.00 short, delay of 4 weeks on prescriptions."

Region 7

VAMC Oklahoma City (NSO comment)

"If $25,000.00 can not be transferred to Prosthetics from other sources within the hospital, backlog will be 30 days."

VAMC Dallas (NSO comment)

"There is continual strain on prosthetic funding. However, when a shortage occurs, surplus funds for other services or programs are rerouted to prosthetics."

VAMC San Antonio (Medical Director comment)

"Prosthetic funding shortages - $200,000"

Mr. Chairman, these comments are very telling. It is obvious to PVA that some veterans just are not getting what they need. We simply cannot accept on the basis of our findings Mr. Turnage's statement that "we may not get all we want, but we get all we need to do our job well."

Finally, it appears that ten years of cost-shifting and the rechanneling of program funds has finally caught up with the VA resulting in critical shortages throughout the system. Nicks and cuts in the VA system made in the name of "creative financing" have, over time, in actuality, created a series of unstable links which connect the veteran to VA health care delivery. Such erosion, over time, has created pitfalls which trip up the veteran on his road to recovery. Although the VA may not say to an eligible veteran, "you cannot come here," their message to sick and disabled veterans just well may be, "we don't have room for you here." In the end, the result is the same.

Mr. Chairman, it is time for a full and accurate accounting of the budget needs and priorities of the VA for the benefit of our nation's veterans and our nation as a whole.

ATTACHMENT A.

, VA outpatient clinic
San Diego, CA

ATTENTION --

EFFECTIVE MONDAY, AUGUST 15, 1988, PATIENTS REQUIRIN
URGENT OR UNSCHEDULED CARE WILL NOT BE SEEN AT
FACILITY.

THOSE PATIENTS SHOULD REPORT TO THE ADMISSION/TRIA
AREA AT THE VETERANS ADMINISTRATION MEDICAL CEN
3350 LA JOLLA VILLAGE DRIVE.

ATTACHMENT A1

VA OUTPATIENT CLINIC-SAN DIEGO

The VA Outpatient Clinic is making adjustments due to the loss of a nurse practitioner. The remaining 5 nurse practitioners include 4 who are full-time employees and 1 who works part-time(one day a week) in a special AIDS clinic. The patient caseload for the remaining professional employees has been increased since they must absorb the patients assigned to the lost nurse practitioner. The VA does not plan to fill the vacant position. Consequently, effective August 15, 1988 the Outpatient Clinic has posted notice (see enclosure) that patients requiring urgent or unscheduled care will not be seen. The patients are directed to the VA Medical Center which is approximately 12 miles northwest of the outpatient clinic. This rather drastic measure of turning away veterans seeking medical care is allegedly due to the loss of the nurse practitioner position.

Apparently the clerical staff is also being affected. Morale is reportedly low and the employees are sometimes required to work temporarily at the VA Medical Center due to the heavy patient caseload at that facility.

Veterans who have a medical urgency or insist on being seen without an appointment will be given a medical evaluation to determine the urgency of their medical condition. However, category C veterans are being denied medical care effective April 11, 1988 (see enclosed letter). These veterans are being advised to seek medical care in the private sector. Additionally, other veterans are given a future appointment when they report without an appointment. In the past, each nurse practitioner served as "Officer of the Day" resulting in veterans without an appointment being seen in most cases. This designation has been eliminated.

ATTACHMENT B

VETERANS ADMINISTRATION MEDICAL CENTER
DENVER, COLORADO

APR 14 1988

BULLETIN NO. 88- 48

(119)

NONREFILLABLE PRESCRIPTIONS

The products listed on the reverse side will no longer be refillable by Pharmacy Service. These products are self limiting as defined by their intended use and continuing need is not justified. These items are available to provide for a smooth transition from inpatient care to home care. When writing prescriptions for these items, you are reminded to consider carefully the time required for their use and to indicate the appropriate amount required on the prescription when forwarded to Pharmacy Service.

FRED SALAS
Medical Center Director

DISTRIBUTION:

116 - 25
11B - 20
127 - 5
111 - 30
112 - 20
136B - 20
119 - 30

EXPIRES: April 1989

ATTACHMENT B1

NONREFILLABLE OVER-THE-COUNTER MEDICAL SUPPLIES

D PAD, STERILE 5x9
DOMINAL PAD
ETAMINOPHEN 325mg TAB
ETAMINOPHEN 500mg/15cc ELIX (237ml btl)
COHOL ISOPROPYL
COHOL PREP PADS
ND, SZ 4 THRU 8 (BURN NET)
NDAGE, ADHESIVE
RRIER STERILE FIELD
DSIDE DRAINAGE BAG
UX, BLUE
VOL 4105 TOP URINAL
VOL 4157 URINAL BOTTOM
VOL 4175 24oz LEG BAG
ASTIC GAUZE 3x5
PHENHYDRAMINE 12.5mg/5ml ELIX
PHENHYDRAMINE 25mg CAP
NE MESH GAUZE
UZE 4x4 STERILE UNFILLED
UZE PADS, TOPPERS 4x4
UZE SPONGES, 2x2 STERILE
OVE, COTTON
OVES, NON-STERILE
OVES, STERILE SURG
DROGEN PEROXIDE
RLIX 4½" ROLL
G BAGS
RTIN TRACH-SECURE
GUIRE 050804 URINAL
NTGOMERY STRAP
GAUZE
-HOPE WAIST AND OSTOMY BELT
-SITE
D, INCONTINENCE LARGE
NTS, INCONTINENCE MEDIUM
PERMA-TYPE TAPE D-126L
POVIDONE IODINE GAUZE PADS
POVIDONE IODINE OINT AND SCRUB
POVIDONE IODINE PREP PADS
POVIDONE IODINE SOLUTION
POVIDONE IODINE SHAMPOO
PROTECTIVE BARRIER FILM WIPES
SWEEN CREAM
TAPE, 1" CLOTH (ADHESIVE)
TAPE, 1" PAPER AND TRANSPORE
TAPE, 1" DERMICLEAR
TAPE, 2" PAPER
TELFA PADS
TOLNAFTATE 1% SOLUTION
TOLNAFTATE 1% TOPICAL POWDER
TRACH BRUSHES
ULTRASOUND TRANSMISSION GEL
UNITED 1110 BONGORT
UNITED 3206 SEMI DISP POUCH
UNITED 3406 URINARY POUCH
UNITED 4023 UNI-SOLVE WIPES
UNITED 4026 UNI-SOLVE ADHESIVE REMOVER
UNITED 4050 URI-KLEEN PT
UNITED 4120 BANISH II 37.5ml
UNITED 4121 BANISH II 237ml
UNITED 4202 SKIN PREP AEROSOL
UNITED SKIN BOND 4oz
UREA 10% CREAM 75g
URINAL, PLASTIC
UROCARE 7001 DRAIN VALVE
UROCARE 8010 SPORT BAG
UROCARE DELUXE LEG STRAP KIT
UROLUX SOLUTION 16oz
VASELINE PETROLATUM GAUZE
XEROFORM DRESSING

ATTACHMENT C

VETERANS ADMINISTRATION
SALEM, VIRGINIA 24153

AUG 31,1988

[redacted]

[redacted]

Dear [redacted]

A consultation was sent to one of our specialty clinics for evaluation of your medical problems.

Currently this specialty clinic is only accepting service connected veterans for evaluation and/or treatment. For this reason, we are unable to schedule you for this clinic. We suggest that you seek care for this condition in the private sector at your own expense.

I regret that we are unable to assist you with this request. I am enclosing a phamplet that explains your eligibility for medical benefits. Should you have any additional questions, please call Mr. Williams at (703) 982-2463, extension 2350 or Mrs. Harrah, extension 2824.

Sincerely yours,

DONNA S. LANCASTER, Chief
Medical Administration Service

Enclosure

America is #1
Thanks to its Veterans

DAILY BULLETIN

THURSDAY, APRIL 7, 1988

Veterans
Administration
Medical Center
San Diego, CA.

MITTING AND TRIAGE OFFICERS

8:00 AM - 8:00 AM -- 24 HRS. (MOD)	5:00 PM - 8:00 AM (SOD)
Dr. Videen	Dr. Auerhan/#412

Attachment D

DESIGNATION

SERVICE	ABSENT	ACTING	DATE
Chief of Staff	J. G. Parthemore, M.D.	L. Henderson, M.D.	4/7/88

****

EARTHQUAKE PREPAREDNESS MONTH

Here's today's tip to help you prepare for and survive a major earthquake in Southern California.

Store three to seven days' supply of non-perishable food for emergency use. Be sure you have a non-electric can opener and utensils to eat with and cook in. Camp stoves, charcoal fired and bottled gas barbecues can be use for heating foods. Rotate your emergency food supply with your regular canned goods to ensure against spoilage.

San Diego Be Aware -- Prepare!

****

SERVICE TO VETERANS IN ELIGIBILITY CATEGORY "C"

Effective Monday, April 11, 1988, this Medical Center (to include the Mission Valley Outpatient Clinic) will begin to discontinue the provision of service to veterans in eligibility category C. This discontinuation of service is due to a decline in the availability of resources. Medical Administration Service will be developing the implementation plan for this change and they will be disseminating this information to the staff. It i important to remember during this process of curtailment that it is Medica Administration Service who will make the eligibility determination and advise the veterans. All veterans will receive an evaluation to determin the urgency of medical care required, however, not all veterans will be entitled to the recommended future care.

This will be a difficult time for all of us, but more importantly for thos veterans who will be informed that they will not be able to receive care.

Should you have any questions concerning this, please contact John Corrow or Rene Duhamel at extension 3474.

ATTACHMENT E

Medical Center
[illegible]

Veterans
Administration

In Reply Refer To: 664/136

Dear Veteran:

It is with great regret that I must advise you of some measures that we must take to reduce the workload at this Medical Center and the Mission Valley Outpatient Clinic.

Effective April 11, 1988, we will begin a process to discontinue services to those veterans who are in the eligibility category C. You have been identified as one of them. This measure has been necessitated because of the decline of available resources. According to established guidelines, veterans in the eligibility status of category C, can be afforded medical care based on available resources at the veteran health care center to which they are applying. Our resources at this point have declined and as such, we must begin to reduce our extremely high workload.

For those category C veterans who have future appointments or admissions scheduled, we ask that you contact our Health Benefits Advisor at 453-7500 extension 3926, for further guidance.

All veterans who report to the Medical Center or the Mission Valley clinic will receive a medical evaluation to determine the urgency of their medical condition, however, category C veterans will not be entitled to care at this facility for the foreseeable future.

For those of you who are receiving medications from our pharmacy, we will be honoring refills for up to two months to allow you the opportunity to obtain medical services from a private physician.

We sincerely regret that this action must be taken and only hope that we can again open our doors to category C veterans at some time in the future.

Sincerely,

Jule D. Morave

JULE D. MORAVEC, Ph.D.
Acting Medical Center Director

Veterans Administration

Memorandum

P.S.
ATTACHMENT F

Date: August 5, 1988

From: Director (00)

Subj: Rescission of previously authorized personnel ceilings and authority to recruit

To: All Service Chiefs

1. The best available estimates indicate that we will have to reduce expenses for FY 1989 by about two million dollars. I have appointed a Budget Deficit Task Force to develop a viable plan for doing so while still maintaining adequate revenues. No activities, programs, or Services are exempt from consideration for cuts. New personnel ceilings for FY 1989 will be determined on the basis of the final plan for budget cuts. Consequently, previously authorized personnel ceilings for all Services must be rescinded and urgently needed positions will be filled only on a case-by-case basis. Urgent personnel needs should be addressed to the Chief, Personnel Service for processing. All previously issued authorizations to recruit replacement employees are hereby rescinded. Commitments that have already been made will be honored but only if Personnel Service attests that a commitment has in fact been made.

2. The Budget Deficit Task Force and I personally are committed to keeping the Medical Center operating as efficiently and effectively as possible. To do so will require cuts and a likely reorganization of some programs and activities. There are no plans to RIF or Furlough any employees but we must operate within the funds available.

3. RESCISSION: None

Mary Ann Coffey
MARY ANN COFFEY

Dist: B

Ioannis A. Lougaris
VA Medical Center
1000 Locust Street
Reno, NV 89520

ATTACHMENT G

COPY
for MAA's
Rae
&
file

June 29, 1988

554/11

Mr. David R. Brady
Assistant Vice-President
Mercy Ambulance of Reno
1050 Bible Way. #5
Reno, NV 89502

Dear Mr. Brady:

As discussed in our telephone conversation today, we ask that REMSA ambulance service avoid bringing patients with SUSPECTED CARDIAC ISCHEMIA to the Reno VA Medical Center, effective immediately.

This Medical Center has no staff cardiologist, and is unable to provide prompt and appropriate care for such patients.

After these patients are assessed and stabilized at other community medical centers, we will arrange for their transfer to the VA on a space-available basis.

Sincerely,

PAUL R. JENSEN, M.D.
Chief of Staff

SHEILA M. CULLEN
Acting Director

bc:

001
136
170

[illegible] S COLUMBIAN WAY, SEATTLE, WA 98108
OPEN AND CLOSED CLINICS--APRIL, 1988

ATTACHMENT H

Consult forms in DUPLICATE are required.

CLOSED CLINICS: MUST be service-connected or posses Special Entitlement Strictly NSC consults will not be forwarded by MAS personnel.

	CLINIC MANAGER
ANTI-COAGULATION-111M	NANCY ROBEN,RN
ARTHRITIS	GORDON STARKEBAUM,MD
AUDIOLOGY	ROBERT MILLER,MD
CARDIOLOGY	JAMES RITCHIE,MD
DAY TREATMENT	REX JOHNSON
DENTAL	DAVID HEID,DDS
ENDOCRINOLOGY/METABOLISM-151 ENDO/META	WILLIAM BREMNER,MD
ERECTILE DYSFUNCTION/IMPOTENCE-112GU	ROBERT IRETON,MD
GASTROENTEROLOGY(GI)-111GI	CHARLES POPE,MD
GERONTOLOGY(GRECC)-182B	MURRAY RASKIND,MD
HEMATOLOGY	GERALD ROTH,MD
HOSPITAL BASED HOME CARE(HBHC)	DENISE SHEA,RN
HYPERTENSION(HTN)-111HTN	DONALD SHERRARD,MD
INSULIN THERAPY	WILLIAM BREMNER,MD
MEDICAL COMPREHENSIVE CARE UNIT-111M	STEPHEN FIHN,MD
MENTAL HYGIENE GENERAL	REX JOHNSON
NEUROLOGY-127	THOMAS BIRD,MD
OPHTHALMOLOGY-112OPH	MICHAEL VANBROCKLIN,MD
OPTOMETRY-112OPH	MICHAEL VANBROCKLIN,MD
RTHO-BACK(must be SC for back condition)	THEODORE GREENLEE,MD
RTHO-HAND,NEW,FOLLOW-UP	THEODORE GREENLEE,MD
ODIATRY-112POD	JOAN WILLIAMS,DPM
ULMONARY	R.K. ALBERT,MD
EHABILITATION MEDICINE(RMS)-117	EUGENE HALAR,MD
ENAL/NEPHROLOGY	DONALD SHERRARD,MD
EIZURE-127	THOMAS BIRD,MD

PEN CLINICS	CLINIC MANAGER
LCOHOL TREATMENT	REX JOHNSON
ENIGN PROSTATIC HYPERTROPHY	STEPHEN FIHN,MD
AY HOSPITAL	REX JOHNSON
ERMATOLOGY	GREGORY RAUGI,MD
IABETIC FOOT ULCER-111M	JESSE AHRONI,ARNP
RUG DEPENDENCY TREATMENT	REX JOHNSON
AR/NOSE/THROAT(ENT)-112OTO	ALLEN HILLEL,MD
ENERAL SURGERY	H.M. RADKE,MD
NECOLOGY-111M	PATTI PAYNE,RN
UNG CANCER-111ONC	JACK SINGER,MD
UNG EDUCATION(PULM)	NANCY RISSER,RN
ENTAL HYGIENE SELECTED CLINICS	REX JOHNSON
EUROSURGERY	KIM BURCHIEL,MD
NCOLOGY-111ONC	JACK SINGER,MD
IN CLINIC-112ANESTH	LOUIS JACOBSON,MD
RIPHERAL VASCULAR SURGERY(PVS)	EUGENE ZIERLER,MD
ASTIC SURGERY-112	JORDON GOTTLIEB,MD
INAL CORD INJURY(SCI)	CATHERINE BRITELL,MD
OKING COUNSELING(MCCU)	NANCY RISSER,RN
ECIAL DIAGNOSTIC PROCEDURES	SENT TO SERVICE
OLOGY-112GU	ROBERT IRETON,MD

inics with mail stops require the consult to be sent to the service office, all closed inic referrals must go thru 136B for eligiblity determination. Any consults not quiring eligiblity determinations may be sent directly to Centralized Scheduling

Department of Medicine
and Surgery
Western Region

211 Main Street
San Francisco CA 94105

Veterans
Administration

Attachment I

June 2, 1988

In Reply Refer To: 10BA6

Directors (00)
All Western Region Medical Facilities

SUBJ: Financial Condition of VAMC San Francisco.

1. The Medical Center at San Francisco is facing a significant financial deficit in FY 88. Addressing the problem is a region wide responsibility and requires resolution prior to September 30, 1988.

2. This letter is a request for all facilities to review their status of funds and volunteer to provide a loan to the San Francisco Medical Center in FY 1988. Funding is needed in the fourth quarter of FY 1988. Repayment of the loan, by VAMC San Francisco, will be accomplished over the shortest period [illegible] time possible i.e., 1-3 years and will be effected by adjustments to the facilitys' AACS prior to the start of each fiscal year of the payback period.

3. Although this letter is confidential, Directors will want to share its content with their Chiefs of Staff and Associate Directors. To volunteer a loan in FY 1988 and collect funding back in future fiscal years should have the full support of the medical center triad.

4. Confidential letters concerning funds available for loan should be sent to my attention. A response to this request by June the 17th, 1988 would be appreciated.

R.E. Lindsey Jr.
R. E. LINDSEY JR.
Regional Director
Western Region

ATTACHMENT I 1

WESTERN REGION (10BA6)
211 MAIN ST., SUITE 1800
SAN FRANCISCO, CA 94105

June 7, 1988

10BA6

Medical District Director (MDD26)
Medical District #26
VAMC Menlo Park Division
795 Willow Road
Menlo Park, CA 94025

SUBJ: Contingency Plan for VAMC San Francisco

1. The Medical District 26 staff is requested to coordinate a district contingency plan to care for VAMC San Francisco patients should VAMC San Francisco deplete their operating funds the fourth quarter of this fiscal year. As we have discussed, I have initiated action within the Western Region to solicit funds for a loan for VAMC San Francisco to augment their budget this year. If funds are not available within the region and/or the San Francisco Medical Center's estimate of this deficiency is not correct, we must develop a plan so that there is the least possible disruption to patient care activities and the quality of patient care is not affected.

2. I have discussed development of a contingency plan with the Acting Director at VAMC San Francisco. I have also discussed the issue with the Acting Director, VAMC Martinez and the Director at VAMC Palo Alto, and they will serve as the backup facilities for VAMC San Francisco. All three Directors will designate someone on each of their staff to work with the medical district staff in developing the contingency plan.

3. You are requested to submit a copy of the completed plan to my San Francisco office by cob June 30, 1988. Thank you for your cooperation.

R. E. LINDSEY, JR.
Regional Director
Western Region

Signed And Dispatched

cc:
VAMC San Francisco (00)
VAMC Palo Alto (00)
VAMC Martinez (00)

Medical Center
Castle Point NY 12511

ATTACHMENT J

Veterans Administration

July 1, 1988

In Reply Refer To: (533/001)

Mr. James J. Peters
Executive Director
Eastern Paralyzed Veterans Association
432 Park Avenue South
New York, NY 10016

Dear Mr. Peters:

I have received your letter of June 27, 1988 along with the results of your recent survey.

Let me begin my response by thanking you for the responsible and professional manner in which your survey was accomplished. We also wish to thank you for your words of praise for our staff. We agree that our staff are among the best in the Veterans Administration medical care system.

The contents of your survey, as it relates to individual support Services, are being provided to those Services along with the request to incorporate, where appropriate, those issues which should be included as part of our quality assurance program.

The issues of staffing and numbers of beds are much more complex matters to completely address. You are correct in stating Spinal Cord Injury at Castle Point is an authorized sixty bed program but, as I'm sure you recall, we will eventually reduce to 56 beds as a result of renovations on Wards E-1 and D-1, with six of those beds designated for plastic surgery on Ward D-1.

Several issues about bed composition for the near future must be clearly explained. Due to staffing shortages in Nursing we were compelled to reduce our actual operating beds to 196 which we believe matched our staffing levels to ensure safe and adequate patient care. Although we have received approval of special salary rates for Nurses and LPN's, there has been no impact relative to our ability to recruit new staff. This is a dilemma for which we have no answer and it indeed remains a major problem for the entire nation. Needless to say, as the summer months approached, we became very concerned about our ability to allow any of our nursing personnel to take vacation time without severely compromising safe patient care. We chose to reduce 12 additional beds for the

J 1

summer months which included a reduction of four in SCI. We sincerely regret the necessity of this decision but I think you will agree that our staff must be granted some relief or we may lose additional staff.

The long term situation for total beds calls for the final composition of beds to be as follows:

E-1	32	SCI
D-1	24	SCI
E-2	42	MED/INT.
D-2	0	WILL REMAIN CLOSED
E-3	42	MED/INT.
D-3	39	SURG.
MICU/SICU	8	
NEW WING	30	INT./REHAB.
TOTAL	217	

The above numbers will require adjustments for the next three years for several reasons. The new ward will be the swing ward as we do ward renovations. Please note the new ward has a 30 bed capacity while most of the wards being renovated have larger capacities. We believe that due to renovations and staff shortages we will be operating at between 178 and 196 beds for at least the next three years.

Lastly, let me advise you that our budget hearings will be held in mid July. The result of the resource allocation model indicates we will be reduced by at least $485,000.00 in FY 89. Our supply costs (i.e., Pharmacy ward stock, etc.) increased by more than $800,000.00 in FY 88 over FY 87 and our Services are requesting significant increases beyond our expenditure rate in FY 88 for FY 89. I know you are aware that we must fund our essential supplies and the remaining budget dictates the level of staffing we are able to support. We also believe we may be asked to absorb part or all of the proposed January pay raise. Additionally we may have a further one percent productivity cut.

I.2

3.

Mr. James J. Peters

The scenario we present is factual as we understand it. This facility must now reconsider its total mission and consider reductions in services if we are to function in a rational way at least for the near future.

The last paragraph of your letter says it best: "The excuses of we cannot hire staff, we don't have money, staff is not available, are no longer valid." I regret that our excuses must in all reality be accepted as fact.

Please continue to support Castle Point as you always have and believe me when I say we hear your concerns and share your frustration.

Sincerely yours,

for Canton
JIM A. FERGUSON
Associate Director

Edward Hines, Jr.
Hospital

Hines IL 60141

Veterans
Administration

ATTACHMENT K

August 24, 1988

In Reply Refer To: 578/00A

Carmen Gonzalez, Jr.
National Service Officer
Paralyzed Veterans of America
V.A.R.O., Room 400
Federal Building
536 S. Clark Street
Chicago, IL 60605

Dear Mr. Gonzalez:

The following information is forwarded in reply to your memorandum dated August 11, 1988:

Item #1: Clinical Staff Shortages (as of 8/24/88):

Ambulatory Care	.5 FTEE Health Technician
Blind Rehab	3.0 FTEE Blind Rehab Specialists
	1.0 FTEE Medical Clerk
Diagnostic Radiology	1.0 FTEE Neuroradiologist
	1.0 FTEE General Radiologist
	1.0 FTEE Diag Rad Technician
	1.0 FTEE Medical Clerk
Dietetic	3.0 FTEE Dietitians
	1.0 FTEE Diet Technician
	5.0 part-time Service Workers
Extended Care Center	6/8's MD
	5/8's MD
Lab	8/8's MD
	4/8's MD
	4.0 FTEE Medical Technologists
	1.0 FTEE Histology Path Tech
	2.0 FTEE Medical Technicians
Medicine	2.0 FTEE Respiratory Therapists
	2.0 FTEE Hemo Techs
Neurology	6/8's MD
Nuclear Medicine	2.0 FTEE MD's
	2.0 FTEE Nuclear Medicine Technologists
Nursing	27.0 FTEE RN's
	40.0 FTEE LPN's and NA's
Pharmacy	1.0 FTEE Chief
	1.0 FTEE Clinical Pharmacist
	1.0 FTEE Pharmacy Tech
Prosthetics	1.0 FTEE Asst. Chief
Psychiatry	2.0 FTEE MD's
	2.0 FTEE Rehab Techs

K 1

Psychology	1.0 FTEE Clinical Psychologist
	1.0 FTEE Vocational Rehab Specialist
Rehab	1.0 FTEE Manual Arts Therapist
	1.0 FTEE CT
	5.0 FTEE OT's
	4.0 FTEE PT's
Social Work	5.0 FTEE Social Workers
Surgical	1.0 FTEE Nurse Anest.

Item #2: Admission Waiting Lists: There is not currently a formal means for collecting or reporting the number of individuals on the waiting list for elective surgery. We were able to determine, however, that there are currently six patients awaiting plastic surgery for decubitis.

Item #3: Category B, C Treatment Referrals: We do not have a policy for deferring treatment or stopping treatment of Category B, C veterans, nor do we turn NSC veterans away or delay treatment in OPC's.

Item #4: Prosthetic Funding Shortages: Our current backlog of orders is minimal. This is because the Chief, Prosthetic Treatment Center has taken a very active role in improving the efficiency of his Service. Specific examples include no longer issuing backup wheelchairs; no longer issuing sports wheelchairs; we are renting more equipment with an option to buy once funds become available; we are suggesting against specialized orders; some OT equipment has been discontinued; very strict medical need criteria are applied against each request; we are extending the life of equipment by repairing it beyond the 50% mark; and we are reissuing and refurbishing many more items than in the past (over 22% as compared to the last FY). We are very proud of the fact that we have the lowest cost per issue for the Great Lakes Region.

Item #5: Facility Budget Info:

	FY87	FY88	FY89(TA)
Workload Reductions	- 2,625,583	0	0
RAM Adj.	+ 1,029,063	+ 910,478	- 1,814,104
Productivity Adj.	- 867,292	- 357,078	- 937,855
Unfunded Inflation Cost	- 1,200,000	-1,000,000	- 800,000
MEDIPP Tax	0	0	- 588,540
Unfunded Special Salary Rates	- 194,867	- 991,338	- 618,980
DHCP Savings	0	- 77,005	- 111,185
CALM Savings	0	0	- 45,095
Homeless Taxes	0	0	- 291,073
Other	0	0	0
TOTALS:	- 3,858,679	- 1,514,943	- 5,206,832
Total FTE Adjustments	+ 9.3	- 96.2	- 85.8

Item #6: Number of nursing vacancies as of 6/30/88: 27.1 RN's and 36.2 LPN's

Item #7: RN Staffing compared to private sector:

Number of RN FTEE: 636
Number of Operating Beds: 1, 144 (Hospital), 1,383 (Hospital + Extended Care Center)

K2

A current American Hospital Association (AHA) survey (1987) indicates that in private sector Illinois hospitals, the average registered nursing hours per patient day is 5.95 for medicine and surgery combined. VAH Hines' average is 2.48 nursing hours/patient day for medicine and surgery (based on RN FTEE of 186.6 and an ADC of 364 for medicine and surgery combined). Thus, patients in private-sector hospitals receive more than two times the amount of nursing care than they would receive in a VA hospital. This is true not only because we have fewer nurses, but because the nurses we do have out on the wards are spending more and more time doing non-patient types of activities; activities such as inputting data and orders into DHCP, patient escort, picking up supplies from SPD, bed cleaning, emptying trash, taking specimens to the lab, etc.

Cut-throat competition exists throughout the Chicago area for recruitment of nurses. The VA is not at all competitive due to its cumbersome method of requesting special salary rates. Of the 400 GNT's we trained last year, one accepted a position here. The others refused, indicating that there are too few nurses on the ward, not enough support staff and low pay.

The obvious question then becomes: why are the nurses spending more time doing non-hands-on types of activities? Because the ancillary support staffing levels are not what they should be, according to VACO standards. For example, based on the Manpower Planning Division Staffing Report for the first quarter FY 1988, "earned FTEE" levels exceeded "actual FTEE" levels in Building Management (Sanitation: 246.99 vs. 175.50); Clinical Lab (152.90 vs. 117.40); Medical Administration (296.16 vs. 269.58); Pharmacy (99.89 vs. 88.73); Rehabilitation Medicine (60.74 vs. 57.21); and Social Work (55.14 vs. 51.94). Historically, these support services have demonstrated a percentage of effectiveness (earned FTEE/actual FTEE x 100) well in excess of 100%. This means that we're doing more with less, and the nurses up on the wards are having to cover where our shortages are. Based on the few services which this report calculates "earned vs. actual", VAH Hines "earned" 101 more FTEE than we have. This equates to $3,434,000 more in salary dollars which we "earned" but which are not forthcoming.

In the article "As margins fall, executives forge survival tools," Hospitals, March 20, 1988, pp 48-52, a comparison was made regarding staffing levels and number of beds in the private sector. Using their methodology, we extrapolated what our FTEE per occupied bed percentage would be (please refer to enclosed graph). According to this article, private-sector hospitals of 500 beds or greater have 5.16 FTEE per occupied bed. VAH Hines has 3.01 FTEE per occupied bed. In order for us to match the private-sector standard, we would require an additional 2,214 FTEE, and approximately $77,000,000 in salary dollars.

Feel free to contact my Management Support Administrator, Mr. George A. Welton, at (312) 343-7200, extensions 2511 or 2512 if you have any questions regarding this response. Thank you for the opportunity to provide this information to you.

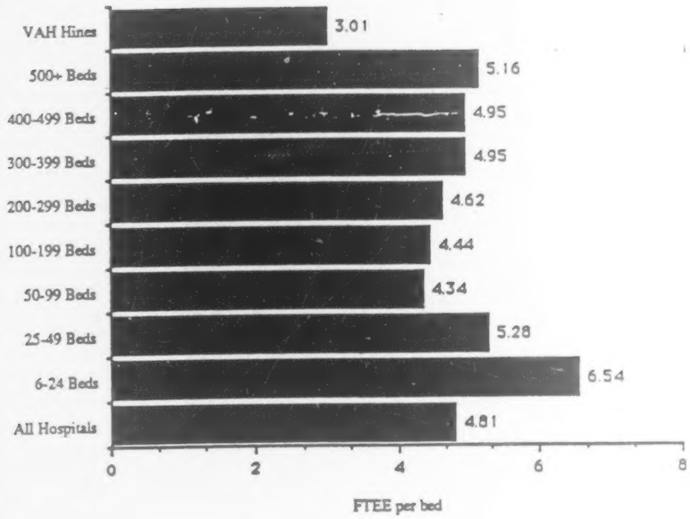
William R Best MD

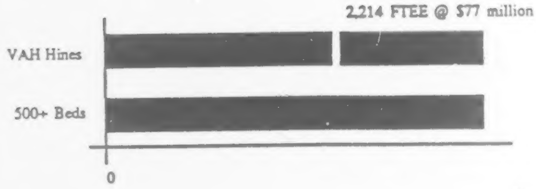
"FOR AND IN THE ABSENCE OF"
JOHN R. FEARS
Director

Enclosure

K3

Comparison of VA Hines Hospital FTEE per Occupied Bed with that Reported in Community Hospitals:





Source: "As margins fall, executives forge survival tools," Hospitals, March 20, 1988, pp 48 - 52.

Veterans Administration

Memorandum

West Roxb. VAMC

Attachment L

May 12, 1988

From Chief, Prosthetics & Sensory Aids Service (121)

Subj Prosthetic's Operating Budget

To: Clinical Service Chiefs

This is to inform you of the status of the Prosthetics' operating budget as of this date.

1. The entire third quarter budget has been spent. Additional funding has been requested but will not be made available.

2. The only funds that will be available between now and Oct. 1 is our fourth quarter budget, $79,500, which has already been cut to $77,500.

3. I have requested an advance on our fourth quarter budget of $24,600 to enable me to purchase some items which are medically urgent and cannot be delayed any longer.

4. This leaves a total of $52,900 operating funds available for Prosthetics between now and Oct. 1, 1988. There is no indication that any more funds will be made available in the fourth quarter.

5. There are many items which will have to be delayed until July, and some which may have to be delayed until October. We are working with very limited resources. Please be as conservative as possible in prescribing equipment. Something provided for one veteran will mean that another may have to do without.

6. With the help of our Orthotic Lab we are doing all we can to repair and reissue equipment whenever possible. Only items determined to be medically urgent will be ordered. Anything that can be delayed, temporized, or substituted will not be ordered at this time. Your patience and cooperation will be appreciated.

David J. Chandonnet

DAVID J. CHANDONNET

CC: Ernest M. Barsamian, M.D.
Acting Medical Ctr Director
Roger Johnson, Acting Associate Director
Prosthetics Staff - West Roxbury
Prosthetics Staff - Brockton

VA FORM 2105

Vietnam Veterans of America, Inc
2001 S St., NW
Suite 700
Washington, DC 20009-1125

(202) 332-2700

Statement Of

VIETNAM VETERANS OF AMERICA, INC.

Presented By

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Before The

SENATE VETERANS AFFAIRS COMMITTEE

On

DEPARTMENT OF MEDICINE AND SURGERY RESOURCES

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Mr. Chairman and members of the Committee, the Vietnam Veterans of America, Inc. (VVA) appreciates the opportunity to present it's views on the VA Health Care System. During the last fiscal year and this fiscal year we have had the opportunity to assist the VA Health Care System (VAHCS) in some growth and development. We believe that the system, perhaps for the first time in many years, or even for the first time, is under scrutiny for the health care (HC) product it delivers directly to the veteran patient. We, as many others, have noted the many favorable contributions the VAHCS has made to the veteran and to the public at large in areas of biomedical research, AIDS care, medical education and to prosthetic and orthotic advancement. We have taken note of the VAHCS acceptance of some risk in exposing itself to the public and increasing its dialogue with the Veteran Service Organizations (VSO). For this we credit Dr. John A. Gronvall, Chief Medical Director (CMD). Given the incentives against interacting with the veterans community and the impossibility of achieving any true field-level individual accountability in such a large highly centralized system, Dr. Gronvall deserves a salute and our full support in terms of what he has been able to accomplish.

However, during the last two years we have also seen just how difficult it is for the highly centralized VAHCS to manage the quality and maintain the product of health care at any given VAMC. In fact, they cannot. Testimony, investigations, and the like, whether from the Chairman of an Oversight

Committee on the subject of phantom beds and elusive staff, or the GAO's questions about the quality of care, or the general inquiries of the VA as to why they would desire to either eliminate or underfund health programs that help veterans at the expense of solid clinical strategies, or even from the press reporting on a medical center director having decided to deny a group of veterans health care, all point to a system that has sacrificed its mission in favor of its own centralized bureaucratic enertia.

In a letter sent to the Chairman of this committee earlier this year, we pointed out that the single most pressing problem or issue for the VAHCS is the questionable quality of health care at the medical center level. The inability to control, direct, and manage the medical center from the medical center itself is creating serious problems. Given all of the oversight by management above the medical center director level, the system has now become dangerous for both veteran patient and VAMC management. The situation has lead to a kind of institutional paralysis where the director and key staff dare not engage in decision-making without checking with "CO", "Operations", "Regional", or "Resources". Clearly the best recognition of this devastating problem is the creation of the Management Efficiency Pilot Program (MEP), an experimental program which allegedly allows five VAMC's to operate relatively independent of the centralized hospital system. This experiment is intended in part to determine if VAMC's can do a better job without the heavy handed interference of Central Office. Unfortunately in this experiment while these VAMC's may have some control over their staff ceilings, they certainly have no control over the resource allocation system or methodology (RAM) which determine if these centers are losers or winners. If they are winners - as in the majority of these cases, they are not allowed to keep all of their gains. This brings about the very lack of management flexibility intended. In short, the MEP is a failure. It is our belief that most if not all of the quality of care issues come down to a matter of local management. Currently the VAMC's are unable to be held accountable or be given the authority and responsibility to properly manage.

It is our further belief that the VAMC's should be given direct responsibility for managing all of their appropriated health dollars. At present, too many appropriated resources are absorbed by the Regions and Districts for administrative staffing and bureaucratic gamesmenship. Without converting the VAHCS into a truly decentralized system, management decisions will continue to be made by those furthest from the patients and the continuing result will be poor care and unmet needs. The balance to this testimony will offer recommendations which we believe can facilitate decentralization. Additionally, we will make some recommendations designed to promote greater VAMC staff sensitivity to the relationship between service connection and eligibility for health care. These in turn should facilitate better attitudes and compassion in the medical care staff and produce a better health care product.

When the Chairman of this committee asked some months ago what was the most pressing issue effecting the VAHCS, we responded by saying that it was the quality of care. It still is! As we all now know, the means test has been used by some VAMC's to turn veterans away. Others have used the RAM for the same purpose. Under the circumstances, shrinking resources can no longer be ignored. Yet the Administrator has appeared in the media stating that the VA is delivering more and better health care in spite of resource limitations.

Nevertheless, we know that the VA has projected a shortfall of better than $600 million for FY89 in its health care budget. As you know, for example, Department of Medicine and Surgery Health Care Region I (DMS HCR) has lost as much as $10 million on its target allowance while Region 7 has gained $8 million on its target allowance. That one region can gain and another region can lose so much while both share essentiallly the some needs make no sense whatsoover.

The five Management Efficiency Pilot hospitals cited above are fully subject to the VACO directed RAM system which limits control over their personnel ceilings. This bodes poorly for the success of the experiment, but the remainder of the VAMC's are in even worse condition having virtually no sense of ownership over their resources. Necessarily, the patient consumer has no say in the matter whatsoever. Quality care at times is available in the VA, but this is more by accident than by VACO design. The good care that is available in the VA is afforded not because of but in spite of the interference and meddling of the Regions whose big Quality Assurance, Utilization and Review, Computer, and Education and Clinical Affairs staffs consume so many resources. The VAMC's are reeling under the management pressure of the Regions, the Districts, VACO, the Medical Affiliates, the local community, the press, the Veteran Service Organizations, the Congress, and a myriad of competing regulatory forces at all levels. This has the effect of subordinating quality health care to bureaucratic and political survival. Upon discussing these problems with VAMC personnel, the record of some Medical Centers is one of day to day struggling just to carry the work load, struggling to reduce the excessive influence on the VAMC's in day to day operations, struggling to dampen losses under the RAM and struggling to keep low visibility but necessary health care programs such as in alcoholism, drug detoxification, contract Half-Way housing, and PTSD and struggling to simply manage the unmanageable.

VAMC Management

VA Central Office officials will tell you that the VAMC medical center directors (MCD's) enjoy a decentralized decision-making process and are in charge of their hospitals. They will also tell you that, with regard to RAM outcomes and

Medical Center programs, VACO has a laisee faire policy. What they fail to acknowledge is that there are 7 Medical Regional Offices who determine and dictate what the VAMC's get under the RAM and who "take the heat" for VACO. This enables the VACO to say they don't make local VAMC decisions. Since these Regional Offices serve at the bidding of VACO, decisions are based on political priorities and agenda rather than clinical priorities. Is it any surprise then that the Regions have yet to devise a Quality Assurance program which can or will ascertain the impact of the RAM on the quality of clinical care?

Because of these Medical Regions, VACO makes no clinical commitment to the VAMC's. The VACO and the Regions, whether or not by design, actually sponsor competition between Medical Centers based on a RAM system driven not by the clinical needs of veterans but by a zero sum resource allocation game carried out in the name of productivity and efficiency. The VACO is fond of saying that the Medical District Initiated Peer Review System is maintaining the quality of health care. Unfortunately, it appears that in the various districts where these systems are in place, they are doing different things without standards or consistency and none of them are looking at the RAM impact on the quality of care to any significant degree. The sad result is that some Medical Center Directors are now desperately forced to produce weighted work units at any cost to include, for example, the logging of flu shots as ambulatory surgical visits and turning away veterans desiring "non-productive" services. VA officials also state that the RAM does not generate new dollars and that the RAM should not be used to justify programs. But try to tell that to a Medical Center Director who loses hundreds of thousands of dollars on his/her adjusted target allowance, and see what impact such a loss has on programs and direct patient care.

As we have noted in our letter to the Chairman identifying the quality of health care as the single most pressing issue facing the VAMC's today, the Medical Center Directors are unable to operate free of outside interference from VACO. Instead, they can only react.

Recommendations

- Total health care coverage should be provided for all service connected conditions as well as for adjunct conditions. The Means Test should apply to all non -service connected conditions. For example, a veteran service-connected at 10% for a skin condition should receive total health care coverage at no cost for that skin condition as well as for service-connected adjucnt conditions. The same veteran, however, should be Means tested for all other health care problems unrelated to those service-connected conditions. In another example, if a veteran is 50% service connected for a neuro psychiatric condition and the physician determines that the patient's physical complaint is related to the neuro psychiatric condition, the physical condition should be treated as an adjunct condition and the means test should be waived.

* All Congressionally mandated special programs such as the Center for PTSD Recovery, Geriatric Research, Education and Clinical Centers (GRECC) and the proposed Mental Illness Research, Education and Clinical Center (MIRECC) should either be exempt from the RAM or totally subject to the RAM, but not both or some combination.

* To preserve and vigorously support the DRG/RAM application for psychiatry without ignoring the diversity of psychiatric diagnosis, and all of the diagnostic gradations therein, the DRG/RAM for psychiatry must be more realisticly structured. The attached 1983 study conducted at Coatsville VAMC attempts to

discern nursing workload based on proposed psychiatric diagnostic groups. (See attached study). In 1983 the Chief Nurse pointed out that there was a greater variation in work resource requirements in the care of the mentally disabled than are normally programmed for in the VA.

Create a governing board of veteran consumers at each VAMC. The board functions should include but not be limited to:

i Holding the VAMC Directors explicitly accountable for clinically based management of the VAMC and for the provision of quality care in all areas.

ii Participation in all major decisions in the management of the VAMC, particularly if it relates to resources, affiliations, programs and key clinical and administrative appointments.

iii Participation in policy implementation when VACO urges adjustments concerning health matters.

- Allow the VAMC to initiate and design its own annual budget plan first. The VAMC should do this within the DRG/RAM rules, but the Medical Center Director should be required to justify his/her budget requests by tailoring VAMC resource needs to the veterans it serves and relative to the specific needs of the community where it is located. This may mean the VAMC will have to contract for some services and/or sell other services to sharing hospitals or health systems in that same community. The relationship between the VAMC and the VACO should be one in which the VAMC sells services to VACO and VACO pays the medical center to provide services for veterans.

- The DM&S Medical Regions must be eliminated. Other than draining resources from the Medical Center level, and serving as a launching pad for internal VA political advancement and interference regarding Resource Allocation, these Regional Offices make few valuable contributions to the well-being of the VAMC or the patients the VAMC is supposed to serve. The DM&S Regional Offices serve only to allow the VA Health Care System to say it is decentralized when in fact it is not.

* Both the DM&S personnel ceiling (and floor) should be eliminated altogether. Maintaining a national level of 194,000 plus health care FTEE without attending to the individual VAMC work loads ignores reality at the local health care delivery level. Such a national ceiling forces top down management to the eventual peril of the veteran in want of quality medical care. Instead, each VAMC should be allowed to justify its own staffing needs based on what is required to get the job done. Among the many problems with centralized management which imposes a national ceiling is that the system cannot adjust to its actual staffing numbers as program needs, workload and bed occupancy rates change. This principle is acknowledged in the 5 Hospital Management Efficiency Programs where there are no ceilings and the Director hires in

for veteran care, the VA should be using those dollars to purchase health care from the VAMC's. The VA needs to become a fiduciary intermediary at the national level and the VAMC's should be given the opportunity to provide these services in exchange for a budget to operate the health care component based on the DRG/RAM system. This relationship between the VA fiduciary intermediary and the VAMC provider needs to be direct, above board, interactive, politically diminished, patient centered, and driven by the desire to provide a quality health care product. The VACO role should be based on national clinical and administrative standards designed to provide the necessary guidelines and constructive support, both technical and professional, to the VAMC in order to facilitate the guarantee of a good product.

* The time has come for veteran customers, as users of the VA health system, to be assured that Medical Center Directors have both the education and experience to manage their hospital systems. Traditionally, VA Medical Center Directors

accordance with program need and resource availability. This is a local management issue, not a national one.

- The 90,000 bed ceiling should be eliminated altogether. Like the personnel ceiling, this too has been a failure as a management tool. The recent House Committee review has clearly demonstrated that serious problems have developed in which there are phantom beds, beds counted but out of service due to staffing shortages, beds counted but out of service due to construction, beds sometimes counted and sometimes not but which are simply out of use and/or awaiting transition. It would appear that the VA is unable to determine how many truly operating beds, from a planning perspective, are actually operational in the centralized system. This is an issue for local management, not national. The individual medical center, must be allowed to size itself based on health needs, determined at the local level, rather than by the central office.

- After Congress appropriates the dollars have come from all disciplines such as personnel, engineering, medicine, administration, social services, supply recreation, pharmacy, nursing, etc. We strongly recommend that regardless of what the discipline, the Medical Center Director have a graduate credential in health management systems. A few examples include Public Health Administration, Hospital Administration and Health Institutions Policy and Planning. Further, these health professionals should belong to a professional organization such as the American College of Health Care Executives or an accredited health care organization for which there is continuing education relative to current developments in the health care management and delivery fields. Even though having such credentials and belonging to such organizations offers no guarantee of competence, the exposure to the issues associated with operating health systems in the VAHCS can go a long way toward assisting the VA Medical Center Director in managing a complex health care system. Moreover, VAMC Directors meeting these standards and with the full responsibility and authority to create and manage their own budgets and facilities should be an improvement.

- Marketing and outreach strategies should be implemented as a means for forcing the VAMC's to deliver a better product. The VA almost hides from those it serves and therefore has no means of accountability for what it does. If the VA is concerned that too many aging service connected veterans in this country will suddenly flood the system, then it may be appropriate to authorize the service connected veteran to use a health provider of his or her choice at VA's expense.

Mr. Chairman, some of these recommendations will appear too bold. Nevertheless, is it too much to ask that the American veteran be given an opportunity to assure quality by managing his or her own system? We think not.

Mr. Chairman, this concludes our testimony.

Veterans Administration

Memorandum

Date 11-3-83

From Chief, Nursing Service (118)

To Medical Center Director (00)
THRU: Chief of Staff (11)

Subj Staffing

1. There is an acute nursing shortage at Coatesville Veterans Administration Medical Center due to the totally inadequate FTE ceiling allocated to Nursing Service. As of 9/30/83 there were 146.4 (FTE) staff nurses, 85 (FTE) LPN's and 371.2 (FTE) nursing assistants providing direct patient care. Asking these personnel to provide quality care to over 900 deserving veteran patients 24 hours/day, 7 days/week is unreasonable in light of present day standards.

2. Specifically one requirement of the agency supporting the JCAH standard of individualized treatment protocols for every patient is that in fact the agency meets that standard. That standard requires that the psychiatric patient be treated in the same manner as the surgical patient i.e. individually not as a "herd of the same". The implication of this standard is clear: the staffing "game rules" for psychiatric facilities which formerly allowed very low staff/patient ratios must change.

3. We are simply not providing good patient care. Personnel are "burned out", overworked and frustrated. Some patient falls, some patient to patient assaults, some patient to employee assaults, some patient elopements, and some patient regressions can be attributed to lack of staff. (Please refer to Appendix I "Substantiating Patient Data".) In light of the patient care mix and the increased work load, the allocation of additional nursing personnel to Nursing Service at C.V.A.M.C. is mandatory.

4. This proposal defines the type of nursing care that should be provided to the patient population at C.V.A.M.C. The FTE direct care requirement was calculated based on providing minimal and optimal care. A mid-point direct care FTE was also determined. The total FTE direct care requirement for providing minimal, midpoint and optimal care is as follows:

Total FTE Requirement		
Minimal	Midpoint	Optimal
1073.5	1437.9	1802.3

5. Therefore, this proposal is submitted in demonstration for the need for additional nursing staff at C.V.A.M.C. The nursing ceiling at C.V.A.M.C. is 660.8 FTE. Approximately 36 FTE are required for administrative, educational and specialty positions such as Infection Control and Quality Assurance Nurses. A synopsis of the additional nursing direct care FTE requirement at the minimal, midpoint, and optimal levels is as follows:

Total Additional FTE Nursing Requirement		
Minimal	Midpoint	Optimal
448.7	813.1	1177.5

6. The specific request for additional direct care nursing staff at C.V.A.M.C. is 813.1 FTE based on the midpoint level.

THOMAS A. SHERWOOD, R.N.

INTRODUCTION

Historically health care facilities have been identified with treating certain prototype patients. This proposal identifies the 13 prototype patients at Coatesville VA Medical Center, defines the care required by each prototype in the form of nursing interventions, allocates an optimal, minimal, and midpoint time factor to the intervention(s) and computes the nursing FTE requirement to provide such care. (Please refer to Appendix II "Explanation of Terms & Calculations".)

A synopsis of the Average Daily Patient Census (A.D.P.C.) of each prototype group, the Nursing FTE Requirement Per Prototype Patient, and the Total Nursing FTE Requirement Per Prototype Group is:

		A.D.P.C. of Prototype Group	Nursing FTE Requirement Per Prototype Patient (Based on Midpoint Level)	Total Nsg. FTE Requirement Per Prototype Group (Based on Midpoint Level)
1.	The Acute Psychiatric Patient	150	1.79	269
2.	The Intermediate Psychiatric Patient	170	1.08	183
3.	The Chronic Psychiatric Patient	132	1.56	205.6
4.	The Substance Abuse Detoxifying Patient	20	1.62	32.4
5.	The Substance Abuse Rehabilitation Patient	90	0.84	75.6
6.	The Post Traumatic Stress Disorder Patient	13	1.23	16
7.	The Pre Outplacement Patient	49	0.5	24.9
8.	The Acute Medical Patient	* 5	2.96	14.8
9.	The Medical Patient	* 71	1.83	130.5
10.	The Geriatric Patient	201	1.23	246.2
11.	The Alzheimers Patient	20	1.28	25.6
12.	The Chronic Neurological Patient	29	1.51	43.9
	(Inpatient) Total	950		1267.5
13.	The Ambulatory Care Patient (Outpatient)	125	0.19	23.4
	New N.H.C.U. (Geriatric)	* 120	1.23	147.0
	GRAND TOTAL =	1195		1437.9

*NOTE: A.D.P.C. was not utilized. In these instances current or projected operating beds were utilized to determine the required nursing FTE because of the temporary closure of beds and the projected opening in December 1983 of the new Nursing Home Care Unit.

Implementation of the proposal would enable Nursing Service at Coatesville VA Medical Center to provide better nursing care to the entire patient population. Currently patients are either not receiving the appropriate care or the provision of that care is at such a minimal level that it could be considered non therapeutic.

Examples of direct and indirect care that patients at Coatesville VA Medical Center are not receiving because of the nursing staff shortage include the following:

1. Patients are not receiving individualized attention; the special needs of each patient cannot be consistently met resulting in fragmented or imcomplete care.

2. Patients are not given the opportunity to interact enough with staff; patient problems are not identified and resolved adequately, patients cannot express their feelings, staff cannot assist the patient in dealing with anxiety, hallucinations or delusional thinking.

3. Patients are not receiving sufficient amounts of care that is prevention oriented prior to crisis situations when there is a potential for acting out or violent behavior.

4. Patients are not receiving adequate amounts of supervision and observation on the off-tours of duty, weekends and holidays.

5. Patients are not being initially, consistently, or continually re-assessed both mentally and physically for revision of their treatment plans.

6. Patients are not receiving the full benefits of planned socialization groups, activities, off station trips and other therapeutic modalities such as Reality Orientation.

7. Patients are not receiving enough assistance in Activities of Daily Living; there is an insufficient number of grooming groups, patients are not being fed in an unhurried manner, turning and ambulating patients is not as frequent as required and the initiation of such specific patient programs such as bowel and bladder re-training is hampered.

8. Patients are not receiving enough required information in the form of patient education in regard to their medications, treatments, etc.

9. Patients are not being adequately prepared for discharge into the communi basic living skills such as menu planning, simple food preparation, bedmaking or money management cannot be taught to the patient on a consistent basis.

10. Patient's families are not being interacted with on a consistent basis t enlist their support and assistance for the patient or to provide them w support, education and re-assurance from a nursing perspective.

11. Patient's clinical records do not sufficiently reflect the actual status of the patient thus having a direct impact on Quality Assurance Reviews and an indirect impact on patient care.

12. Patients are often "lost" within the multiplicity of services provided; often privileged patients do not attend scheduled therapies, etc. Nursing Service does not have sufficient time to provide the required coordination and follow-up in such instances.

In reviewing this proposal there are certain considerations that must be kept in mind. The prototype patient as described is the "typical" patient. Within each prototype group, there are patients who require more nursing hours per patient day and there are patients who require less nursing hours per patient day. For example, the identified midpoint NHPD for the Acute Psychiatric Patient is 10.25; in those instances, which are frequent, where a patient is placed on Suicidal Status, continous 24 hour observation by an identified member of the nursing staff is required. If a newly admitted psychiatric patient is not acutely psychotic, the number of NHPD may be less than 10.25. Throughout the proposal each nursing intervention is timed; a range is provided from the optimum amount of time required to the minimal amount of time required. The midpoint was utilized to determine the required FTE.

In some instances interventions can be done simultaneously. The determination of the viability of performing simultaneous interventions must be based on the clinical judgement of the practitioner and the condition of the patient. Since the overall patient population at CVAMC tends to be psychotic, or regressed, or chronic, or a total care patient, the performance of simultaneous interventions is often times difficult.

Many of the interventions as defined such as participating with the patient in recreational or diversional activities may appear to be in the province of another service. The point is well taken, however; in a neuropsychiatric facility, patients, especially because they are psychotic, regressed, etc. need the type and amount of patience, care, supervision and reinforcement that services such as Recreation cannot totally provide. In this instance nursing and the other service must work in a collaborative manner. It is also important for nursing personnel to observe the patient away from the unit setting. Much valuable information about the patient can be gained through this participative and observational function.

Another consideration the reader of this proposal may have concerns itself with what an additional 813.1 FTE would do to the Core Staffing Ratio at CVAMC. The Core Staffing Ratio for FY 1982 at CVAMC was 1.47 based on an ADPC of 904.7. The Core Staffing Ratio is calculated based on the guidelines set forth in VA Circular 10-79-259, dated November 5, 1979. Implementation of this proposal, using an ADPC of 904.7 would increase the Core Staffing Ratio at CVAMC to 2.24; an increase of 0.77. Utilizing this proposal's projected ADPC and operating beds of 950, the Core Staffing Ratio at CVAMC would increase to 2.13; an increase of 0.66. Considering the complexity of services required by the psychiatric patient, who in many instances also has medical problems, this increase does not appear to be exhorbit
Historically GM&S facilities have had higher Core Staffing Ratios than neuropsych

facilities. The care required by the psychiatric patient is not any less demanding or complex in comparison to the patient in a GM&S facility; it is merely provided from a different perspective. In addition C.V.A.M.C. has become affiliated with Thomas Jefferson University. The assumption that provision of better patient care through medical school affiliation will occur through the implementation of new programs is an accepted premise. New and expanded programs generally require more staff.

The submission of this proposal for an additional 813.1 FTE in Nursing is a large request. For that reason, no calculation was included to cover the non-productive time of the additional 813.1 personnel requested. Within the private sector this figure is usually around 15%.

Nursing service at C.V.A.M.C. realizes that it is obligated to provide safe care to the veteran population and has been forced to use overtime in situations where patient care could be unsafe because of lack of staff. During the 1983 Fiscal Year Nursing Service authorized approximately $223,000.00 in overtime. This amount was approximately $45,000.00 over what was authorized in Fiscal Year 1982. The average RN salary at C.V.A.M.C. is $29,024.00, the average LPN/NA salary is $17,710.00. This computes to 7.7 FTE RN's or 12.6 LPN/NA that were needed to provide "bare" coverage. There is no reason to believe that overtime will not continue to escalate to provide that "bare" coverage. The question is "Is this use of overtime the best way to allocate resources?" Clearly the answer is no; individualized treatment of the veteran patient cannot occur with this system.

THE ACUTE PSYCHIATRIC PATIENT

The Acute Psychiatric Patient may be in the age range of 22 to 70 years. The patient has had previous multiple psychiatric admissions and frequently has a history of past suicidal attempts and/or acting out behavior. The patient is typically irritable and angry. Self destructive behavior may be demonstrated. Drug and alcohol dependency is common. The patient is most often not in touch with reality; hallucinations and delusional thinking are commonplace. Personal hygiene is generally lacking and the nutritional status of the patient is poor. External and family support systems are minimal.

Nursing interventions for this patient include:

	NHPD		
	Minimal	Midpoint	Optimal
1. Crisis intervention and providing a safe environment to protect the patient from self harm or harming others. Included is constant observation when it is necessary to place the patient in seclusion or restraints.	1.12	1.50	1.88
2. Developing and maintaining a therapeutic relationship with the patient to give support and encourage the patient to verbalize fears, feelings, and anxieties.	1.50	2.00	2.50
3. Monitoring and ensuring that the patient ingests adequate amounts of food and fluids at mealtime. This may include actually sitting with the patient at mealtime to encourage eating and in some instances feeding the patient.	0.19	0.25	0.31
4. Assisting the patient in performing activities of daily living including dressing and grooming.	0.56	0.75	0.94
5. Monitoring the sleeping patterns of the patient and taking appropriate actions such as talking to the patient or giving the appropriate sleep medication when the patient is unable to sleep.	0.56	0.75	0.94

		NHPD	
	Minimal	Midpoint	Optimal
6. Orienting the patient to reality. This includes consistently reminding the patient who he is and where he is.	0.75	1.00	1.25
7. Re-directing the patient's thoughts when hallucinations or delusional thinking are demonstrated.	0.75	1.00	1.25
8. Assisting and encouraging the patient to participate in therapeutic activities such as playing pool and swimming. Included is the actual escorting of the patient to the activity.	0.56	0.75	0.94
9. Administering medications to the patient and assessing the therapeutic and possible side effects of the medication.	0.56	0.75	0.94
10. Educating the patient regarding the psychiatric illness, substance abuse dependency problem, associated treatments, and medications.	0.37	0.50	0.63
11. Administrative time required to process admissions, make rounds with physicians, initiate physicians orders, document on the clinical record, participate in patient care planning meetings, and coordinate unit functioning with the associated administrative requirements.	0.75	1.00	1.25
TOTALS	7.67	10.25	12.83

A.D.P.C. of Prototype Patients at CVAMC = 150
Number of Nursing Hours required for all patients/day = 1537.5
Number of Nursing Hours required for all patients/week = 10762.5
Number of Nursing FTE required = 269

THE INTERMEDIATE PSYCHIATRIC PATIENT

The Intermediate Psychiatric Patient can be in the age range of 22-70 years but most commonly is in the middle age group. Schizophrenia, Paranoid Type is the most frequent psychiatric diagnosis. Often this patient has a secondary diagnosis of alcohol, drug, or combined alcohol/drug dependence. This patient is in the sub-acute phase of the illness and is still prone to relapses. Previous hospitalizations have been frequent for varying lengths of time. This re-admission tendency is fostered by a poor support system and lack of vocational skills. The patient is usually delusional, has hallucinations and exhibits poor impulse control. Acting out behavior is common and often related to the ingestion of alcohol and/or drugs. The patient is uninterested or incapable of performing basic activities of daily living and therefore is institution dependent. Close observation and supervision of this patient is required. Discharge planning is difficult because of the multiplicity of problems and the use of outpatient treatment facilities is sporadic between hospitalizations.

Nursing interventions for this patient include:

	NHPD		
	Minimal	Midpoint	Optimal
1. Encouraging the patient to participate in therapeutic activities. Included is the actual escorting of patients on off-station trips or participating with the patient in activities such as swimming.	1.12	1.50	1.88
2. Assisting and encouraging the patient to perform activities of daily living stressing the development of good grooming, bathing and dressing habits.	0.75	1.00	1.25
3. Developing a therapeutic relationship with the patient. The following issues are addressed during the interaction: A. Verbalization of feelings, fears and anxieties. B. Problem identification and resolution. C. Discussion and identification of feelings, thoughts, etc. that initiate the ingestion of alcohol, drugs, or both.	0.75	1.00	1.25

	NMPD		
	Minimal	Midpoint	Optimal
D. Planning for discharge and reinforcement of the importance of utilizing outpatient facilities on a consistent basis.			
4. Managing the patient during periods when agitated behavior or delusional thinking are demonstrated. This may be related to the ingestion of alcohol, drugs or both. Specific interventions may include removing the patient to a quiet area, talking to the patient and/or administering medication.	0.75	1.00	1.25
5. Administering medications and assessing the therapeutic and possible side effects of the medications.	0.37	0.50	0.63
6. Educating the patient regarding the psychiatric illness, dependency problem, treatments and medication.	0.37	0.50	0.63
7. Assessing daily the mental status of the patient to determine the need for care plan revision.	0.19	0.25	0.31
8. Teaching the patient those basic skills such as bedmaking and cooking which will be utilized when discharged.	0.19	0.25	0.31
9. Administrative time required to make rounds with physicians, initiate orders, document on the clinical record, participate in patient care planning meetings and coordinate unit functioning with the associated administrative requirements.	0.11	0.15	0.19
TOTALS	4.60	6.15	7.70

A.D.P.C. of Prototype Patients at CVAMC = 170
Number of Nursing Hours required for all patients/day = 1045.5
Number of Nursing Hours required for all patients/week = 7318.5
Number of Nursing FTE required = 183

THE CHRONIC PSYCHIATRIC PATIENT

The Chronic Psychiatric Patient is in middle or later life and most commonly has a psychiatric diagnosis of Schizophrenia, Undifferentiated Type. Mood swings are typical of this patient ranging from withdrawal to hyperactivity. Delusional thinking and acting out behavior are frequently demonstrated. The patient may be disoriented as to time, place and person and demonstrate symptomotology of an Organic Brain Syndrome. Personal hygiene habits tend to be lacking. The nutritional status of the patient is poor; often there is hoarding of food. The patient manifests signs and symptoms of medical diseases such as Diabetes Mellitus and Chronic Obstructive Pulmonary Disease. Multiple medications are often required to manage both the psychiatric and medical conditions, with poor patient compliance. Support systems and positive interpersonal relationships are often non-existent. Community outplacement is difficult.

Nursing interventions for this patient: include:

	NHPD		
	Minimal	Midpoint	Optimal
1. Monitoring the patient's weight and ensuring the patient ingests adequate amounts of food and fluids to maintain proper body weight. This may require actually feeding the patient.	1.69	2.25	2.81
2. Assisting the patient with total grooming and dressing.	1.50	2.00	2.50
3. Daily outing with the patient or participation in a therapeutic activity, such as swimming, to re-channel energy. This also includes escorting the patient to the activity.	0.75	1.00	1.25
4. Frequent interaction with the patient to encourage the patient to verbalize feelings, thoughts, and needs.	0.75	1.00	1.25
5. Orienting the patient to reality frequently during the day. This may also include inclusion of the patient in a Reality Orientation Program.	0.37	0.50	0.63

	NHPD		
	Minimal	Midpoint	Optimal
6. Intervening when the patient is withdrawn or hyperactive to prevent self or other directed destuctive behavior. This may include removing the patient from the environment to an area where the patient can be closely observed and attended to.	0.37	0.50	0.63
7. Providing a safe environment that protects the patient from injury from the physical surroundings and other agitated patients. Included is the removal of physical safety hazards and the therapeutic management of other agitated patients who have a potential for striking out.	0.37	0.50	0.63
8. Administering medications to the patient and assessing the therapeutic and possible side effects of the medications.	0.37	0.50	0.63
9. Daily assessment of the patient's mental and physical status to determine the need for care plan revision.	0.19	0.25	0.31
10. Educating the patient regarding the psychiatric and medical illness, associated treatments and medications.	0.19	0.25	0.31
11. Administrative time required to make rounds with physicians, initiate orders, participate in patient care planning meetings, document on the clinical record, and coordinate unit functioning with the associated administrative requirements.	0.11	0.15	0.19
TOTALS	6.66	8.90	11.14

A.D.P.C. of Prototype Patients at CVAMC = 132
Number of Nursing Hours required for all patients/day = 1174.8
Number of Nursing Hours required for all patients/week = 8223.6
Number of Nursing FTE required = 205.6

THE SUBSTANCE ABUSE DETOXIFYING PATIENT

The Substance Abuse Detoxifying Patient is generally in the age range of 20 to 70 years and may have an alcohol, drug, or combined alcohol/drug dependence problem. The patient may be a voluntary admission or court stipulated; legal problems are common. Many of the patients also have a psychiatric diagnosis or a personality disorder. The medical problems associated with substance abuse are common and include cirrhosis, peripheral neuropathy, absesses, etc. Typically, the detoxifying patient demonstrates denial of addiction, poor self-esteem and mood swings. Depressive symptomatology, often with previous suicidal attempts is common. Positive interpersonal relationships are lacking in addition to poor social and coping skills. Manipulative and demanding behavior is common; which can lead to acting out behavior. Nutritionally, their status is poor. External support systems are limited.

Nursing interventions for this patient include:

		NHPD	
	Minimal	Midpoint	Optimal
1. Close supervision and monitoring of the physical and emotional status of the patient. This includes assessment of behaviors or signs and symptoms indicative of withdrawal.	2.25	3.00	3.75
2. Providing emotional support to the patient when physical and psychological signs of withdrawal occur. Included is dealing with the associated irritable, frightened or demanding behavior of the patient and limit setting.	1.50	2.00	2.50
3. Frequent interaction with the patient:			
A. To assist the patient in identifying problems and resolutions.	0.75	1.00	1.25
B. To assist the patient to identify those interaction patterns or behaviors which impede the patient's progress.			

	NHPD		
	Minimal	Midpoint	Optimal
4. Crisis intervention when the potential for acting out behavior occurs. This may include physically removing the patient to a quiet area of the unit and "talking the patient down."	0.37	0.50	0.63
5. Monitoring and ensuring that the patient ingests adequate amounts of food and fluids.	0.37	0.50	0.63
6. Assisting and encouraging the patient as allowed to exercise or participate in diversional activities such as swimming to re-channel energy. This includes actual escorting of the patient to the activity.	0.37	0.50	0.63
7. Administering medications and assessing the therapeutic and possible side effects.	0.37	0.50	0.63
8. Educating the patient in regard to the detoxifying process and the remifications of continued alcohol/drug dependence.	0.19	0.25	0.31
9. Administrative time required to process admissions, make rounds with physicians, initiate orders, document on the clinical record, participate in patient care planning meetings and coordinate unit functioning with the associated administrative requirements.	0.75	1.00	1.25
TOTALS	6.92	9.25	11.58

A.D.P.C. of Prototype Patients at CVAMC = 20
Number of Nursing Hours required for all patients/day = 185
Number of Nursing Hours required for all patients/week = 1295
Number of Nursing FTE required = 32.4

THE SUBSTANCE ABUSE REHABILITATION PATIENT

The Substance Abuse Rehabilitation Patient is usually between the ages of 24 and 50 years. The patient has completed the detoxification process but still remains highly unstable both physically and psychologically. Typically, the patient is angry and lashes out at others especially if they are in authority positions. Acting out may occur since these patients have difficulty adjusting to constraints on their behavior and the expectations of the program. Problem solving and introspective abilities are lacking causing thoughts and emotions to become overwhelming. Patients are typically demanding yet may be depressed; impulse control is poor. Medical problems related to substance abuse dependency are common. Personal neglect is manifested by poor nutritional status. From an educational standpoint, these patients often lack a high school diploma and thus have few skills on which to base vocational planning; employment problems are rampant. A social support system is lacking.

Nursing interventions for this patient include:

		NHPD	
	Minimal	Midpoint	Optimal
1. Developing a therapeutic relationship with the patient and encouraging the patient to participate in group therapy. The following issues are addressed: A. Identifying problems and possible solutions. B. Identifying non-coping stratagies such as denial which impede the patient in the rehabilitation process. C. Dealing with anger and authority figures. D. The importance of the development of leisure time activities.	1.50	2.00	2.50
2. Assessing daily the physical and psychological status of the patient for care plan revision.	0.37	0.50	0.63

	NHPD		
	Minimal	Midpoint	Optimal
3. Assisting the patient in re-directing anger through the use of diversional activities, exercise, and group therapy.	0.37	0.50	0.63
4. Reinforcing the rules and regulations of the program and the expected behaviors of the patient which the patient has agreed to in the form of a contract. Included is dealing with the patient when manipulation or demanding behavior is demonstrated.	0.37	0.50	0.63
5. Educating the patient concerning the dependency problem, complications, nutrition, medications, and general and specific health problems.	0.37	0.50	0.63
6. Crisis intervention including "talking the patient down" to prevent potential acting out behavior.	0.19	0.25	0.31
7. Ensuring and encouraging the patient ingests adequate amounts of food and fluids during meal time.	0.19	0.25	0.31
8. Administering medications and assessing the therapeutic and possible side effects.	0.11	0.15	0.19
9. Administrative time required to make rounds with physicians, initiate orders, document on the clinical record, participate in patient care planning meetings and coordinate unit functioning with the associated administrative requirements.	0.11	0.15	0.19
TOTALS	3.58	4.80	6.02

A.D.P.C. of Prototype Patients at CVAMC = 90
Number of Nursing Hours required for all patients/day = 432
Number of Nursing Hours required for all patients/week = 3024
Number of Nursing FTE required = 75.6

THE POST TRAUMATIC STRESS DISORDER PATIENT

The Post Traumatic Stress Disorder Patient is young to middle age having served in the Viet Nam Conflict. The patient representative of this order has not, in many instances, been able to discuss the combat experience previously. These patients have pent up emotions of guilt, fear and feel alienated from society. Impulsive behavior is not uncommon. Flashbacks and nightmares dealing with the combat experience are common. Low self-esteem and poor interpersonal relationships contribute to their sense of worthlessness. Vocational skills were never developed since the transition from adolescence to adulthood was interrupted by military service. The use of abusing substances is common.

Nursing interventions for this patient include:

		NHPD	
	Minimal	Midpoint	Optimal
1. Developing a therapeutic relationship with the patient and encouraging the patient to participate in group therapy during which the following issues are addressed:			
A. Allowing the patient to verbalize the thoughts and feelings related to the combat experience in a non-threatening secure environment.			
B. Allowing the patient to verbalize current thoughts and feelings.	2.62	3.50	4.38
C. Identification of problems with possible solutions.			
D. Identification of strengths to promote self concept.			
E. Goal setting.			
2. Crisis intervention including "talking the patient down" when there is a potential for acting out behavior.	0.56	0.75	0.94
3. Assisting the patient in redirecting the impulsive and angry behavior through diversional activities and exercise.	0.37	0.50	0.63

	NHPD		
	Minimal	Midpoint	Optimal
4. Monitoring sleeping patterns and taking appropriate actions such as reassuring the patient and/or giving prescribed sleep medications.	0.37	0.50	0.63
5. Educating the patient about the dependency problems, complications, medications and the importance of maintaining good general health status.	0.37	0.50	0.63
6. Administering medications and monitoring the therapeutic and possible side effects.	0.37	0.50	0.63
7. Re-enforcing the rules, regulations and expectations of the program which the patient agreed to upon admission. Included is dealing with manipulative and/or threatening behavior and limit setting.	0.19	0.25	0.31
8. Encouraging and assisting the patient to develop better interpersonal skills through participation in unit activities such as patient government and unit projects.	0.11	0.15	0.19
9. Administrative time required to make rounds with physicians, initiate orders, participating in patient care planning meetings, document on the clinical record, and coordinate unit functioning with the associated administrative requirements.	0.26	0.35	0.44
TOTALS	5.22	7.00	8.78

A.D.P.C. of Prototype Patients at CVAMC = 13
Number of Nursing Hours required for all patients/day = 91
Number of Nursing Hours required for all patients/week = 637
Number of Nursing FTE required = 16

THE PRE OUTPLACEMENT PATIENT

The Pre Outplacement Patient is preparing to re-enter the community or enter a domicilliary after hospital discharge. The patient can be any age. Schizophrenia either Paranoid or Undifferentiated Type or a substance abuse dependency problem are the most common diagnoses. This patient typically has a history of multiple hospital re-admissions and demonstrates severe social disability. Behaviorally the patient is manipulative and aggressive or depressed and passive. In addition, this patient is anxious, institution dependent and has difficulty with authority figures. Vocational skills and goal orientation are lacking. This patient lacks a social support system. In most instances, the patient is ambulatory but may evidence residual effects of chronic medical conditions such as difficulty in breathing. Personal hygiene habits tend to be poor thus comprising the capacity for independent living.

Nursing interventions for this patient include:

	NHPD		
	Minimal	**Midpoint**	**Optimal**
1. Developing a therapeutic relationship with the patient. The following issues are addressed:			
A. Reality testing: "what is" versus the patient's perception of "what is."			
B. Identifying feelings and thoughts and how these may interfere with functioning.			
C. Identifying problems and possible solutions.	1.31	1.75	2.19
D. Dependent/Independent functioning			
E. Providing feedback regarding the patient's style of interaction in dealing with everyday problems.			
2. Educating the patient in regard to specific topics which include:			
A. Medications, therapeutic and possible side effects.			

	NHPD		
	Minimal	Midpoint	Optimal
B. Dealing with the chronic disease.			
C. Re-enforcement of the importance of complying with treatment regimes.			
D. The ramifications of ingesting alcohol, drugs or both.	0.19	0.25	0.31
E. Developing skills in activities of daily living.			
F. Use of leisure time and healthy recreation.			
G. Developing appropriate coping skills to deal with stress and problems.			
3. Monitoring the patient's personal hygiene habits.	0.11	0.15	0.19
4. Setting limits and re-enforcing the program expectations.	0.19	0.25	0.31
5. Monitoring the patient's compliance in taking self medications.	0.15	0.20	0.25
6. Administrative time required to make rounds with physicians, initiate orders, document on the clinical record, participate in patient care planning meetings and coordinate unit functioning with the associated administrative requirements.	0.22	0.30	0.38
TOTALS	2.17	2.90	3.63

A.D.P.C. of Prototype Patients at CVAMC = 49
Number of Nursing Hours required for all patients/day = 142.1
Number of Nursing Hours required for all patients/week = 994.7
Number of Nursing FTE required = 24.9

THE ACUTE MEDICAL PATIENT

The Acute Medical Patient can be any age but typically is in the middle to later years. The patient manifests life threatening conditions which necessitate immediate treatment. These conditions are most often related to the cardiac and respiratory systems and frequently co-exist with a psychiatric diagnosis. Management of the emergent medical condition is complex especially when complications such as renal failure occur. Constant physical and mental assessment of the patient and the monitoring of life sustaining equipment are mandatory. Highly sophisticated and often times emergency procedures are performed requiring a high degree of technical skill. Throughout the process the dignity of the patient must be maintained. Total care of the patient is required.

Nursing interventions for this patient include:

		NHPD	
	Minimal	Midpoint	Optimal
1. Basic care which includes bathing, feeding and toileting.	3.00	4.00	5.00
2. Monitoring the patient who is on a cardiac monitor or is dependent on equipment such as a ventilator.	3.00	4.00	5.00
3. Performing procedures such as suctioning, drawing blood and catheter care.	1.50	2.00	2.50
4. Administering medications, intravenous therapy and assessing the therapeutic and possible side effects.	1.50	2.00	2.50
5. Complete physical assessment of the patient on each tour of duty for the purpose of care plan revision.	1.50	2.00	2.50
6. Providing psychological support and education to the patient and family during the crises.	1.50	2.00	2.50
7. Administrative time required to process admissions, make rounds with physicians, initiate orders, participate in patient care planning meetings, document on the clinical record, and coordinate unit functioning with the associated administrative requirements.	0.75	1.00	1.25
TOTALS	12.75	17.00	21.25

Number of Projected Operating Prototype Patient beds at CVAMC = 5
Number of Nursing Hours required for all patients/day = 85
Number of Nursing Hours required for all patients/week = 595
Number of Nursing FTE required = 14.8

THE MEDICAL PATIENT

The Medical Patient may be a middle aged or later life psychiatric patient with a superceding chronic illness(es) such as Chronic Obstructive Pulmonary Disease or Diabetes Mellitus that is in exacerbation. The patient is acute but does not require life sustaining measures such as mechanical respiratory support. Almost total care is required for this patient including assistance in activities of daily living and close observation. Nutritional status is often maintained through the use of tube feedings. Intravenous infusions, oxygen therapy and complex treatments are often necessary. Skin breakdown and pneumonia are examples of potential problems for this patient. The patient may be disoriented and demonstrate psychiatric symptomatology requiring close behavioral monitoring and re-orientation.

Nursing interventions for this patient include:

		NHPD	
	Minimal	Midpoint	Optimal
1. Providing care which includes bathing, toileting, feeding and ambulating.	2.25	3.00	3.75
2. Close observation and performing such procedures as turning the patient every two hours and catheter care.	2.25	3.00	3.75
3. Monitoring and ensuring the patient ingests adequate amounts of food and fluids. This includes monitoring of intravenous therapy, in some instances feeding the patient or administering tube feedings on a frequent basis.	1.12	1.50	1.88
4. Providing psychological support to the patient and family.	0.75	1.00	1.25
5. Administering medications and intravenous therapy.	0.37	0.50	0.63
6. Assessing the therapeutic value and possible side effects of medications and treatments.	0.37	0.50	0.63
7. Educating the patient with regard to the illness and medications.	0.37	0.50	0.63

		NHPD	
	Minimal	Midpoint	Optimal
8. Administrative time required to make rounds with physicians, initiate orders, participate in patient care planning meetings, document on the clinical record, and coordinate unit functioning with the associated administrative requirements.	0.37	0.50	0.63
TOTALS	7.85	10.50	13.15

Number of Projected Operating Prototype Patient beds at CVAMC = 71
Number of Nursing Hours required for all patients/day = 745.5
Number of Nursing Hours required for all patients/week = 5218.5
Number of Nursing FTE required = 130.5

THE GERIATRIC PATIENT

The Geriatric Patient is 60 years of age or older. The patient has a psychiatric diagnosis and has been associated with the hospital for a long period of time or has been admitted to the hospital with multiple physical problems which impair the ability to live independently. The patient may demonstrate signs and symptoms of an Organic Brain Syndrome. These patients typically have problems with mobility and have sensory deficits in hearing and vision. They are prone to accidents and fractures occur easily. Often their nutritional status is poor. Problems with bowel and bladder elimination are common. Ambulation is at a slower pace. Their sense of self worth is diminished and they may be disoriented as to time, place and person. Frustration is often exhibited by the patient in the form of combative or agitated behavior when they are unable to compensate for their decline in physical abilities. For those patients with aphasia or Parkinson's Disease, the ability to communicate is hampered. Family support is minimal due to lack of family members or illness of the significant other.

Nursing interventions for this patient include:

		NHPD	
	Minimal	Midpoint	Optimal
1. Interacting with the patient in an unhurried manner, encouraging the patient to interact with others, and assessing and re-planning care based on the patient's functional ability and tolerance.	1.50	2.00	2.50
2. Monitoring and ensuring that the patient ingests adequate amounts of food and fluids. This may include assistance at meals or actually feeding the patient.	1.12	1.50	1.88
3. Assisting the patient with activities of daily living including bathing, dressing and grooming.	0.75	1.00	1.25
4. Administering medications and assessing the therapeutic and possible side effects.	0.37	0.50	0.63
5. Providing an environment free from hazards by constant monitoring of the physical surroundings. Assessing the patient in regard to sensory deficits such as hearing and instituting appropriate measures to compensate for any deficit.	0.37	0.50	0.63

	NHPD		
	Minimal	Midpoint	Optimal
6. Assisting and encouraging the patient to participate in recreational and physical therapies. Included is the actual escorting of the patient on off-station trips or to the assigned therapy sessions.	0.37	0.50	0.63
7. Assessing the patient both mentally and physically; this may necessitate placing the patient in a structured Reality Orientation Program or placing the patient on a bowel/bladder training program.	0.37	0.50	0.63
8. Administrative time required to make rounds with physicians, initiate orders, participate in patient care planning meetings, document on the clinical record and coordinate unit functioning with the associated administrative requirement.	0.37	0.50	0.63
TOTALS	5.22	7.00	8.78

A.D.P.C. of Prototype Patients at CVAMC = 201
Number of Nursing Hours required for all patients/day - 1407
Number of Nursing Hours required for all patients/week = 9849
Number of Nursing FTE required = 246.2

Projected Operating Beds for new NHCU = 120
Number of Nursing Hours required for all patients/day = 840
Number of Nursing Hours required for all patients/week = 5880
Number of Nursing FTE required = 147

THE ALZHEIMER'S PATIENT

The Alzheimer's Patient is in the age range of 48 to 72 years and demonstrates symptomatology of late stage 2 or early stage 3 of the disease. This patient is usually well-educated and has an extensive family support system. Psychologically, the patient has profound memory loss, impairment of intellectual functioning and is disoriented as to time, place and person. Communication efforts by the patient are often illogical and incoherent. Functionally, the patient cannot perform the activities of daily living such as toileting, bathing, feeding and grooming. Patients are most often incontinent. Because of the physical decline and the associated inability to function independently, the patient typically becomes frustrated and is often irritable and resistive to care givers. Hightened physical activity is periodically demonstrated. Seizures are not uncommon in this patient. This total care patient requires close observation and supervision.

Nursing interventions for this patient include:

		NHPD		
		Minimal	Midpoint	Optimal
1.	Assisting the patient with bathing, feeding, and grooming.	1.31	1.75	2.19
2.	Assisting the patient at mealtime. This may include feeding the patient or assisting the patient in manipulating the spoon or fork.	1.12	1.50	1.88
3.	Monitoring and providing a safe and predictable environment by continuously supervising the patient on the unit while ambulatory or performing activities. Escorting the patient to activities and appointments is required.	0.75	1.00	1.25
4.	Monitoring the patient's incontinence: changing incontinence pants every 2-3 hours, assisting the patient to the bathroom, or initiating a bowel/bladder training program.	0.75	1.00	1.25
5.	Interacting with the patient in an unhurried manner to provide psychological support and reality orientation. Included is intervening when the patient becomes hyperactive.	0.56	0.75	0.94

	NHPD		
	Minimal	Midpoint	Optimal
6. Assessing the physical capabilities of the patient daily for care plan revision.	0.37	0.50	0.63
7. Administering medications and assessing the therapeutic value and/or possible side effects.	0.37	0.50	0.63
8. Administrative time required to make rounds with physicians, initiate orders, document on the clinical record, participate in patient care planning meetings and coordinate unit functioning with the associated administrative requirements.	0.22	0.30	0.38
TOTALS	5.45	7.30	9.15

A.D.P.C. of Prototype Patient at CVAMC = 20
Number of Nursing Hours required for all patients/day = 146
Number of Nursing Hours required for all patients/week = 1022
Number of Nursing FTE required = 25.6

THE CHRONIC NEUROLOGICAL PATIENT

The Chronic Neurological Patient is in the age range of 35 to 70 years and commonly has a diagnosis of Parkinson's Disease, Multiple Sclerosis, Huntington's Chorea or is a post head trauma victim. Because of the incurred brain damage or the disease process itself, the patient demonstrates an impairment of perception and intellectual and motor functioning. The patient may be fully alert or unconscious. The deteriorating physical condition and the psychological changes associated with the disease process itself causes frustration on the part of the patient. Functionally, the patient is unable to perform self care activities such as bathing, feeding, grooming and toileting; thus is dependent on others to meet these needs.

Nursing interventions for this patient include:

	NHPD		
	Minimal	Midpoint	Optimal
1. Providing basic care which includes bathing, oral hygiene, assisting with toileting, and range of motion exercises.	2.25	3.00	3.75
2. Insuring the patient ingests adequate amounts of food and fluids. This may include feeding the patient or administering tube feedings.	1.50	2.00	2.50
3. Close observation and performing procedures such as suctioning, positioning, and catheter care.	0.75	1.00	1.25
4. Providing psychological support to the patient through frequent and unhurried patient interactions.	0.75	1.00	1.25
5. Administering medications and intravenous therapy. Assessing the therapeutic value and possible side effects of medication.	0.37	0.50	0.63
6. Assessing the patient neurologically and revising care as needed.	0.37	0.50	0.63
7. Educating the patient in regard to the illness, medications and treatments.	0.37	0.50	0.63

	NHPD		
	Minimal	Midpoint	Optimal
8. Administrative time required to make rounds with physicians, initiate orders, participate in patient care planning meetings, document on the clinical record, and coordinate unit functioning with the associated administrative requirements.	0.11	0.15	0.19
TOTALS	6.47	8.65	10.83

A.D.P.C. of Prototype Patients at CVAMC = 29
Number of Nursing Hours required for all patients/day = 250.9
Number of Nursing Hours required for all patients/week = 1755.9
Number of Nursing FTE required = 43.9

THE AMBULATORY CARE PATIENT

The Ambulatory Care Patient is in the age range of 19 to 88 years and may be an outpatient, inpatient, service connected or non-service connected veteran. In addition, employees of the facility are monitored yearly and may be treated under certain conditions. The patient may be treated in one or more of the following areas: 1. Mental Hygiene Clinic; 2. Ambulatory Care including the 14 clinics; 3. Admissions or 4. Employee Health. The patient may have a psychiatric diagnosis, substance abuse dependency problem, acute or chronic medical diseases, or an on-the-job injury in the case of employees. The total number of visits for the year ending September, 1982, was 33,656. The greatest number of patient visits are during the administrative work week; approximately 125 per day.

Nursing interventions for this patient include:

		NHPD	
	Minimal	Midpoint	Optimal
1. Assessing the patient medically and/or psychologically.	0.37	0.50	0.63
2. Coordinating the movement of the patients within the clinics or to other VA facilities.	0.19	0.25	0.31
3. Educating the patient in regard to the disease entity, therapy and medication.	0.19	0.25	0.31
4. Escorting the patient to the unit or to other VA facilities for treatments, procedures, or follow up care.	0.11	0.15	0.19
5. Employee counseling	0.07	0.10	0.13
6. Initial assessment of all admissions	0.07	0.10	0.13
7. Administrative time including documentation on the clinical record and clinic coordination with the associated administrative requirements.	0.07	0.10	0.13
TOTALS	1.07	1.50	1.83

Number of Prototype Patients/day at CVAMC = 125
Number of Nursing Hours required for all patients/day = 187.5
Number of Nursing Hours required for all patients/week = 937.5
Number of Nursing FTE required = 23.4

APPENDIX I

"SUBSTANTIATING PATIENT DATA"

During the month of March 1983, there were 114 Patient incidents reported at CVAMC. Of the 114 reported incidents, there were 64 reported patient to patient assaults. During June 1983, one registered nurse and three nursing assistants were assaulted by patients. The trend of patient and employee assaults has necessitated the implementation of a Psychiatric Emergency Assistance Team at CVAMC which is composed of nursing personnel who are specially trained to manage the potential or acting out patient. Controlling mechanisms such as seclusion or leather restraints have also been necessary. During March 1983, seclusion or leather restraints had to be utilized a total of 41 times. Seclusion was utilized a total of 56 hours; restraints a total of 137 hours and 10 minutes. Total use for both was 193 hours and 10 minutes or 26% of the total number of hours for the month.

Thirty five patient falls were reported for the month of May 1983; 20 of these falls occurred on the medical and geriatric areas. This computes to 57% of the falls occurring in these areas.

Therefore, nursing personnel appear to spend what time they have in managing crisis situations, not planning or implementing or supervising patient care.

APPENDIX II

"EXPLANATION OF TERMS & CALCULATIONS"

For the purpose of this proposal the following terms are defined:

1. Prototype Patient - That patient who most typically represents a group of veterans receiving care at CVAMC.

2. Nursing Interventions - Those specific nursing actions undertaken to resolve an identified patient problem or need.

The calculations of the nursing FTE requirement for each prototype patient at CVAMC was determined by utilizing the Nursing Hour Per Patient Day (NHPD) which is equivalent to 60 minutes. Each intervention was timed as a multiple or proportion of a nursing hour i.e. 2.0 NHPD = 120 minutes, 0.25 NHPD = 15 minutes. Three different times in terms of NHPD were assigned to each intervention; the minimal amount of time required to perform the intervention, the optimum amount of time required to perform the intervention and a midpoint time. The total NHPD for the prototype patient was obtained by summing the allocated times for the interventions. The Average Daily Patient Census (A.D.P.C.) for each prototype patient was determined and utilized in conjunction with the total midpoint NHPD to compute the required nursing FTE.

CONCLUSION

Quality individualized nursing care cannot be provided at Coatesville Veterans Administration Medical Center with the current nursing ceiling.

This proposal as submitted not only has implications for the quality of nursing care that could be potentially delivered at CVAMC but also on a system wide basis. The Veterans Administration as part of the total health care delivery system has many times served as the role model in the clinical, administrative, research and educational areas. From a clinical perspective, the delivery of individualized care has historically been given increasing emphasis from such standard formulating and accrediting bodies as the Joint Commission on Accreditation of Hospitals. Patient rights, patient privacy and hospital responsibility continue to be vital issues. Although such health care legislation as T.E.F.R.A. and the implementation of prospective reimbursement schemes such as D.R.G.'s add the element of fiscal responsibility, the health care professions and particularly the nursing profession in its role as patient advocate must address the quality and quantity of care provided not only in terms of what the patient deserves but also in terms of the responsibility the health care facility assumes in providing that care. This proposal is in fact a first step in defining the many prototype patients found in a hospital identified as neuropsychiatric facility and the nursing care required.

Nursing of course does not provide services within a vacuum. It must collaborate with others within the multidisciplinary setting, most notable are the collaborative efforts required between nurses and physicians. A physician shortage at CVAMC is evident and as such the collaborative efforts needed for the delivery of quality patient care are lacking.

Implementation of this proposal with the subsequent increased nursing ceiling ensures from a nursing perspective that quality individualized nursing care can be delivered.

Thank you for your consideration in this matter.

Veterans
Administration

STATEMENT
OF THE
HONORABLE THOMAS K. TURNAGE
ADMINISTRATOR OF VETERANS' AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
SEPTEMBER 9, 1988

Mr. Chairman and Members of the Committee:

It is a pleasure to appear before you to discuss the funding status of the VA Medical Program in Fiscal Years 1988 and 1989.

Mr. Chairman, there has been a great deal of concern raised from congressional sources about the adequacy of funding of the VA health care program. As was discussed earlier this year during budget hearings, the FY 1989 "bipartisan budget agreement" entered into by the Congress and the Administration as a means of reducing the level of deficit spending impacted on the development of the 1989 Medical Care Request. Domestic agencies were limited in the aggregate to proposing FY 1989 expenditures of no more than 2 percent above FY 1988 appropriated funds for discretionary programs. For VA medical care the President proposed an FY 1989 budget that was more than 2 percent above the FY 1988 level. The agreement further provided that there would be no FY 1988 or 1989 budget supplementals. A few months ago, the Congress passed legislation that expanded VA's authority to provide certain types of care and payments, some of which are mandatory. Two months later, the Congress passed, and the President signed, an appropriation for VA medical care that is over $200 million above the President's request.

Our operating flexibility to implement Public Law 100-322 within the budget levels continues to be limited in FY 1988 and 1989 by Congressionally mandated limits in law such as requirements to operate a minimum number of beds, maintain a specified employment level, and expend a designated amount for personal services.

There is no doubt that this funding environment presents challenges for the VA health care system, however, the system is not on the brink of collapse as has been suggested in some accounts. The VA health care system has a history of facing challenges and overcoming adversity, of management innovation and improved productivity, and of delivering quality services. The VA health care system is a dynamic enterprise that is constantly facing changing demands, creating new programs, discontinuing old programs, developing and implementing new technologies, and achieving greater efficiencies in service delivery.

We in fact monitor very closely the primary indicators of the system with monthly reports that I would like to share with you. Public Law 99-272 established a priority system for the delivery of health care to veterans and established Categories of veterans to which the VA "shall" provide care and categories to which the VA "may" provide care depending on the availability of resources. As a result of that law, we instituted a system to account for every veteran who applied for care (see attached tables 1 and 2). The reports from that system, which I would like to have included in the record, indicate that we have not turned away any veteran who applied for care when VA has an obligation to treat. Additionally, those veterans in the "may" categories who needed care and agreed to make the copayment required by law were also provided quality medical care consistent with their needs.

Each month we monitor selected activities in the medical system to identify trends and attempt to anticipate problems from the system level (see attached charts 1 thru 15). These charts, which I also request be included in the record, reflect the applications, average daily census, occupancy rate and level of outpatient activity within the system. The charts show that there have not been any drastic changes in the level of activity during FY 1988.

A budget document for a given year is a snapshot of requirements nine months before the beginning of the year. Based on my visits to over 50 VA medical centers and my visits with the management of all VA health care facilities during recent internal budget conferences, I am convinced that the system will meet the challenges that we face and that all veterans who are entitled to VA health care will be able to receive it in both FY 1988 and FY 1989.

In FY 1989, the Department of Medicine and Surgery has its highest resource base in history. This provides us with a strong position to continue delivering quality services while we make needed adjustments to accomplish our mission. The passage of Public Law 100-322 helps to clarify long standing ambiguity about eligibility rules for veterans for outpatient care. Congress has now provided a clear definition of those that the VA shall provide care to and those which the VA may provide care to if enough resources are available. I firmly believe that no veteran to whom VA has an obligation to provide care will be denied services in 1988 or 1989. To accomplish this end, some geographic adjustment of resources may be necessary and, yes, we will need to continue to innovate improvements to the VA health care delivery system. While we do this, Dr. Gronvall and I are committed to assuring that services provided will be of the highest quality possible.

Dr. Gronvall and his staff have extensively reviewed the financial and operational condition of the VA health care system and are developing options that may have to be implemented in FY 1989. With your approval I would ask Dr. Gronvall to present his assessment at this time.

TABLE 1

MEDICAL ADMINISTRATION SERVICE 8271
VETERAN ELIGIBILITY AND THE FURNISHING OF HEALTH CARE
FOR MONTH ENDING JUL 31, 1988

TOTAL ALL STATIONS

	VETERAN ELIGIBILITY	NUMBER OF APPLI-CATIONS A	---CARE RECEIVED/SCHEDULED--- HOSP. B	NURS-ING HOME CARE C	DOM D	OUTPAT CARE E	MEDICALLY EXAMINED-NO FURTHER CARE REQ F	CAN-CELED G	NOT ELI-GI-BLE H	TREAT-MENT MODAL-ITY NOT AVAIL I	REF TO OTH-ER FAC J	PEND-ING EOM K	NOT A-GREE ING TO DE DUCT L	ITEM A AS % OF GRAND TOTAL M	OUT OF BAL N
	CATEGORY A														
01	100% SERVICE CONNECTED	14,269	3,887	45	10	9,470	283	386	29	7	147	119		6.03	3
02	90% SERVICE CONNECTED	526	88	1	2	406	16	6	5		2	5		.22	
03	80% SERVICE CONNECTED	1,548	302	5		1,148	24	44	9		16	24		.65	
04	70% SERVICE CONNECTED	3,393	828	16	6	2,311	77	83	25	2	42	63		1.43	
05	60% SERVICE CONNECTED	5,258	1,091	11	9	3,802	108	98	37	2	52	23		2.22	48
06	50% SERVICE CONNECTED	5,600	1,306	9	83	3,882	120	163	17	5	21	32		2.37	
07	TOTAL 50% THRU 100% S C	30,594	7,502	87	110	21,019	628	780	122	16	280	266		12.93	51
08	40% SERVICE CONNECTED	5,869	1,147	14	12	4,421	106	134	15	5	17	18		2.48	
09	30% SERVICE CONNECTED	9,822	2,067	14	17	7,241	174	224	44	12	32	37		4.15	8-
10	20% SERVICE CONNECTED	8,554	1,553	15	18	6,575	148	207	39	12	28	36		3.61	53-
11	10% SERVICE CONNECTED	18,640	3,566	29	40	14,060	349	467	64	18	48	35		7.88	4
12	0% SERVICE CONNECTED	16,467	3,806	41	62	11,764	320	362	60	20	37	22		6.96	1-
13	OTHER SERVICE CONNECTED	1,479	171	2	1	1,196	35	67	21	4	13			.62	29-
14	TOTAL 0% - 40% & OTH S C	60,831	12,310	115	150	45,257	1,132	1,461	243	71	175	148		25.70	87-
15	TOTAL (ITEMS 7 & 14)	91,425	19,812	202	260	66,276	1,760	2,241	365	87	455	414		38.63	36-
16	FORMER PRISONER OF WAR	698	104	10	1	556	15	22	4	1	3	3		.29	20-
17	AGENT ORANGE/IONIZING RAD	6,502	1,528	3	58	4,548	120	185	10	19	24	5		2.75	9
18	WORLD WAR I	1,416	495	23	1	794	55	28	13	1	8	3		.60	1
19	VA PENSIONER	24,052	7,587	90	43	15,197	439	515	82	39	62	26		10.16	1
20	MEDICAID	1,702	482	3	3	1,111	31	57	5	1	8	3		.72	
21	OTHER NSC CATEGORY A	95,604	22,601	208	321	66,835	2,316	2,578	422	154	278	118		40.40	98-
22	TOTAL (ITEMS 16 THRU 21)	129,972	32,797	337	427	89,041	2,976	3,385	536	215	383	158		54.92	107-
23	CATEGORY A TOTAL (ITEMS 15 & 22)	221,397	52,609	539	587	155,317	4,736	5,626	901	302	838	572		93.55	143-
24	CATEGORY B OTHER NSC	8,490	1,788	21	3	6,251	206	171	9	22	17	10		3.59	
25	CATEGORY C OTHER NSC	6,766	1,311	22	2	4,958	186	209	13	21	12	5	30	2.86	1
26	TOTAL CATEGORIES A, B, C	236,653	55,708	582	692	166,526	5,128	6,006	923	345	867	587	30	100.00	142-
27	ALL NON-VETERAN APPLICANTS	2,593												1.10	
28	GRAND TOTAL	239,246	55,708	582	692	166,526	5,128	6,006	923	345	867	587	30	100.00	142-
29	PERCENT OF GRAND TOTAL	100.00	23.54	25	29	70.37	2.17	2.54	39	.15	.37	.25	.01		.06-

NOTE 1 COLUMN L IS FOR CATEGORY C ONLY
2 COLUMN N - APPLICATIONS (COLUMN A) PLUS PRIOR MONTH'S PENDING EQUALS THE SUM OF COLUMNS B THRU L - AN OUT OF BALANCE WILL OCCUR.

TABLE 2

MEDICAL ADMINISTRATION SERVICE 8ZU1
VETERAN ELIGIBILITY AND THE FURNISHING OF HEALTH CARE
FISCAL YEAR TO DATE THRU JUL 31, 1988

TOTAL ALL STATIONS

			---CARE RECEIVED/SCHEDULED---											
	VETERAN ELIGIBILITY	NUMBER OF APPLI- CATIONS A	HOSP. B	NURS-ING HOME CARE C	DOM D	OUTPAT CARE E	MEDICALLY EXAMINED NO FURTHER CARE REQ F	CAN-CELED G	NOT ELI-GI-BLE H	TREAT-MENT MODAL-ITY NOT AVAIL I	REF TO OTH-ER FAC J	PEND-ING EOM K	NOT A-GREE-ING TO DE-DUCT L	ITEM A AS % OF GRAND TOTAL M
	CATEGORY A													
01	100% SERVICE CONNECTED	142,948	40,504	501	136	92,985	4,087	3,986	171	85	710	1,143		6.01
02	90% SERVICE CONNECTED	5,341	1,160	9	11	3,901	115	102	15	1	26	44		.22
03	80% SERVICE CONNECTED	15,182	3,346	47	4	10,953	345	327	68	7	79	238		.64
04	70% SERVICE CONNECTED	33,719	8,357	71	22	23,292	818	847	144	16	151	581		1.42
05	60% SERVICE CONNECTED	51,828	11,354	83	57	37,632	1,223	998	212	20	221	220		2.18
06	50% SERVICE CONNECTED	58,162	13,060	80	207	41,277	1,562	1,487	234	44	248	345		2.44
07	TOTAL 50% THRU 100% S C	337,180	77,781	791	437	210,040	8,150	7,747	844	173	1,435	2,571		12.91
08	40% SERVICE CONNECTED	61,479	12,888	125	121	45,178	1,663	1,300	196	47	203	193		2.58
09	30% SERVICE CONNECTED	103,071	21,986	438	277	74,585	2,925	2,565	384	109	364	262		4.33
10	20% SERVICE CONNECTED	89,319	16,827	125	348	67,240	2,386	1,954	321	133	295	251		3.75
11	10% SERVICE CONNECTED	193,221	37,508	281	409	144,771	5,204	4,378	513	475	700	373		8.12
12	0% SERVICE CONNECTED	162,557	38,473	523	479	113,926	4,394	3,904	432	175	456	233		6.83
13	OTHER SERVICE CONNECTED	15,079	1,734	14	16	12,461	380	426	73	12	67	12		.63
14	TOTAL 0% - 40% & OTH S C	624,726	129,416	1,306	1,650	458,161	16,952	14,527	1,919	951	2,085	1,324		26.25
15	TOTAL (ITEMS 7 & 14)	931,906	207,197	2,097	2,087	668,201	25,102	22,274	2,763	1,124	3,520	3,895		39.15
16	FORMER PRISONER OF WAR	8,000	1,424	30	7	6,096	240	203	20	7	19	18		.34
17	AGENT ORANGE/IONIZING RAD	61,885	14,342	29	233	43,637	1,576	1,693	88	75	241	41		2.60
18	WORLD WAR I	16,024	6,222	251	18	8,756	2,384	277	128	34	34	31		.67
19	VA PENSIONER	248,670	81,360	758	480	152,690	6,552	5,098	779	326	607	247		10.45
20	MEDICAID	18,172	5,058	24	44	12,237	462	550	27	18	59	23		.76
21	OTHER NSC CATEGORY A	947,939	31,496	1,648	3,356	651,041	30,203	23,983	2,723	1,619	2,446	803		39.83
22	TOTAL (ITEMS 16 THRU 21)	1,300,690	339,902	2,740	4,138	874,457	41,417	31,804	3,765	2,079	3,406	1,163		54.65
23	CATEGORY A TOTAL (ITEMS 15 & 22)	2,232,596	547,099	4,837	6,225	1,542,658	66,519	54,078	6,528	3,203	6,926	5,058		93.80
24	CATEGORY B OTHER NSC	80,476	17,425	172	74	58,183	2,612	1,711	75	116	186	52		3.38
25	CATEGORY C OTHER NSC	67,141	14,048	264	37	47,347	2,719	2,046	118	119	124	41	291	2.82
26	TOTAL CATEGORIES A,B,C	2,380,213	578,572	5,273	6,336	1,648,188	71,850	57,835	6,721	3,438	7,236	5,151	291	100.00
27	ALL NON-VETERAN APPLICANTS	30,623												1.29
28	GRAND TOTAL	2,410,836	578,572	5,273	6,336	1,648,188	71,850	57,835	6,721	3,438	7,236	5,151	291	100.00
29	PERCENT OF GRAND TOTAL	100.00	24.31	.22	.27	69.25	3.02	2.43	.28	.14	.30	.22	.01	

*NOTE: COLUMN L IS FOR CATEGORY C ONLY

Chart 1

APPLICATIONS FOR MEDICAL CARE CATEGORIES A, B, AND C

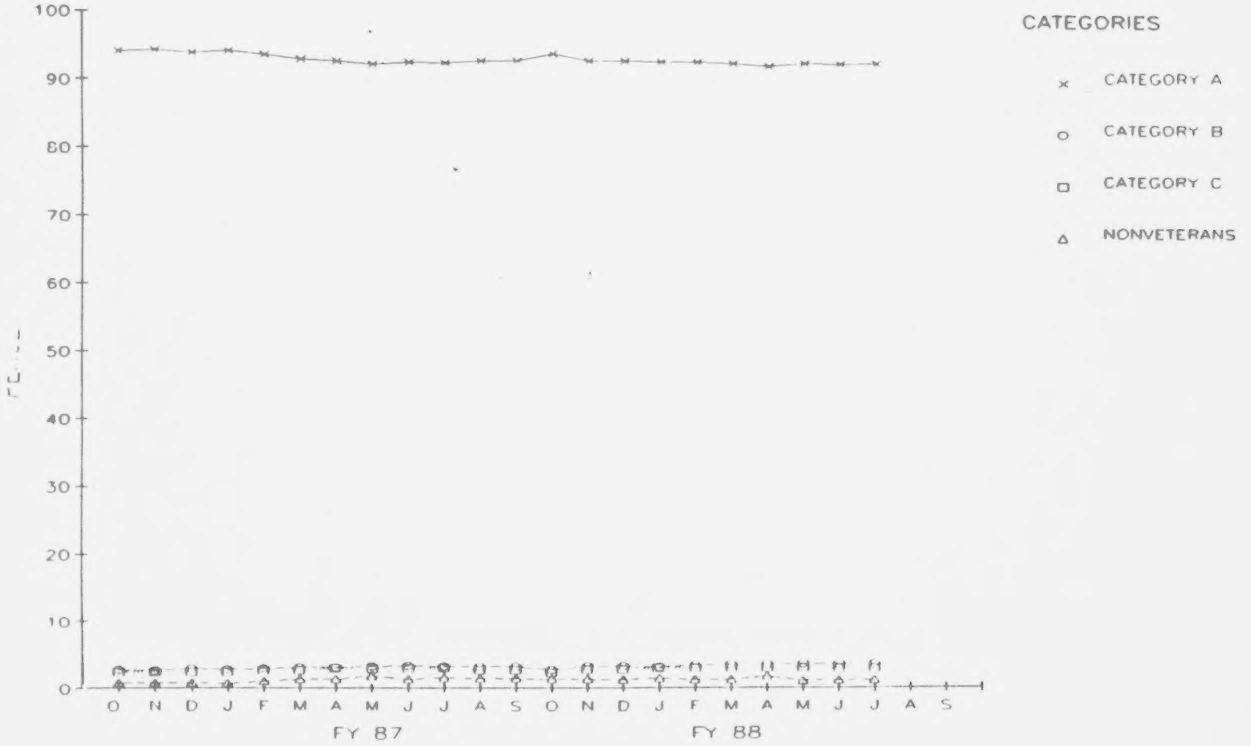


Chart 2

APPLICATIONS FOR MEDICAL CARE
CATEGORY A ONLY

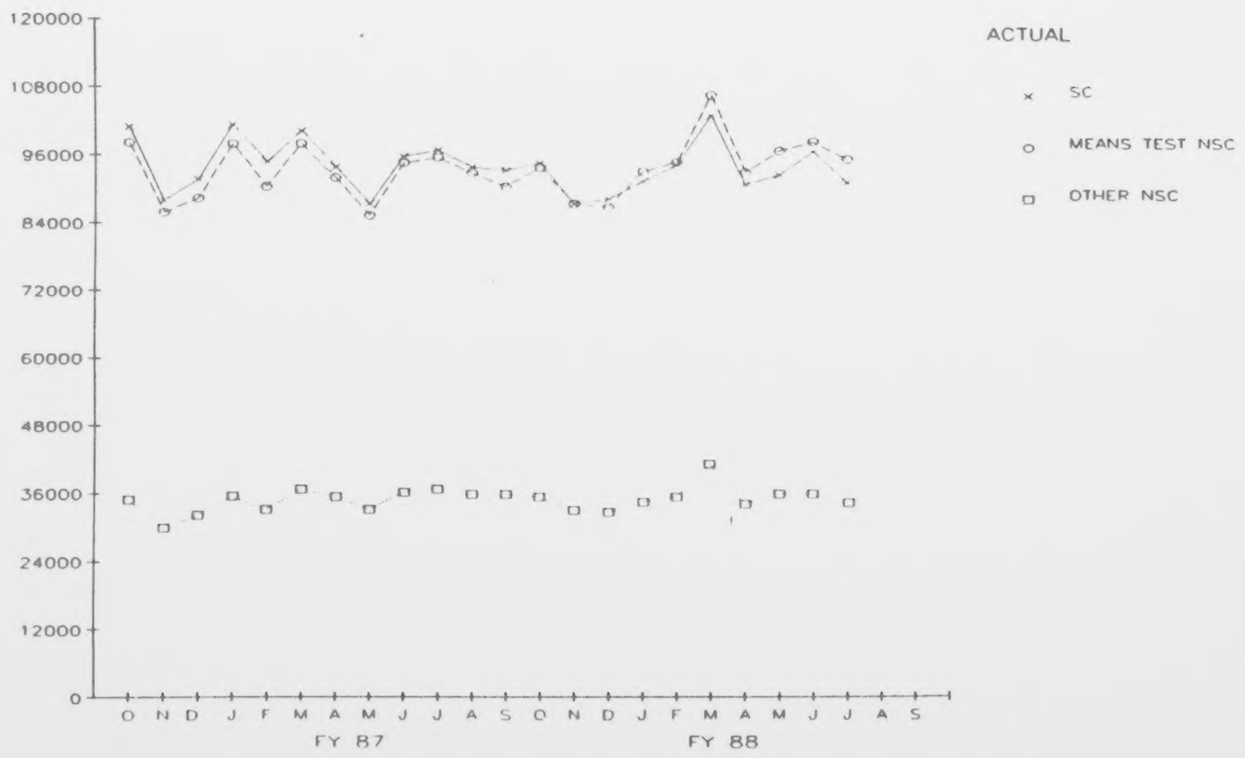


Chart 3

APPLICATIONS FOR MEDICAL CARE CATEGORIES B AND C

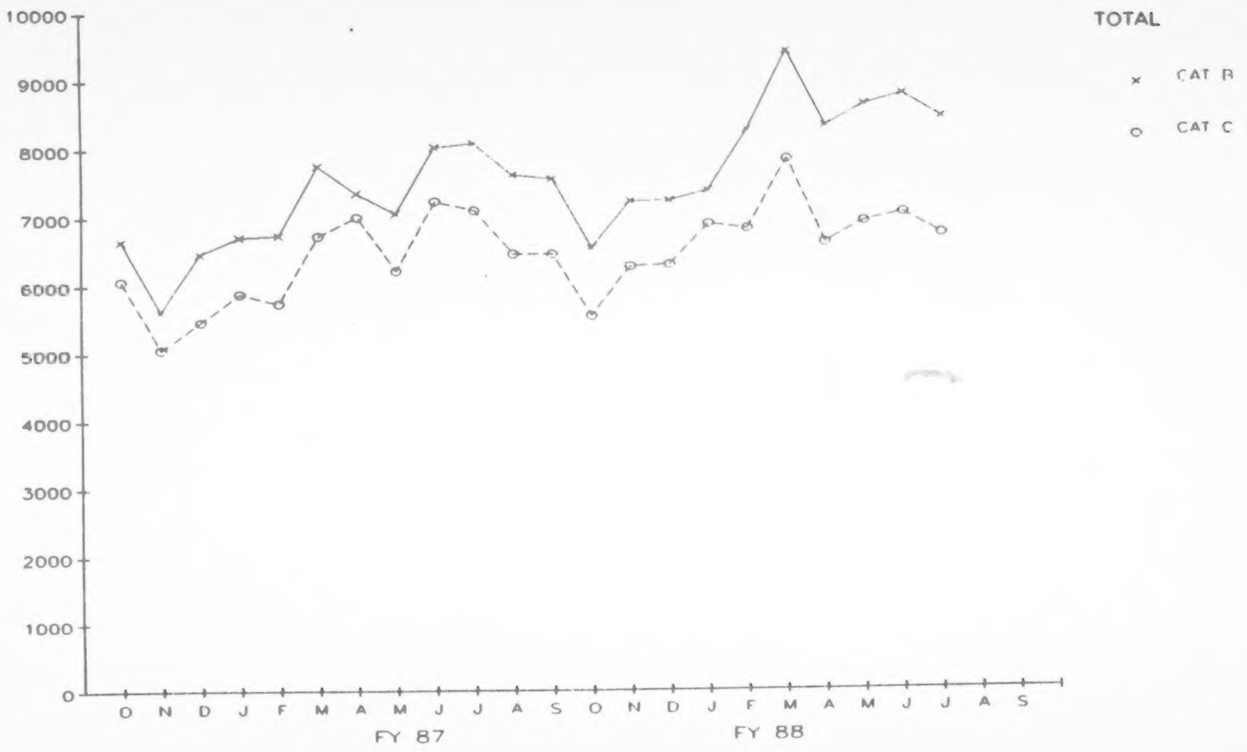


Chart 4

AVERAGE DAILY CENSUS BY BED TYPE
VA HOSPITALS

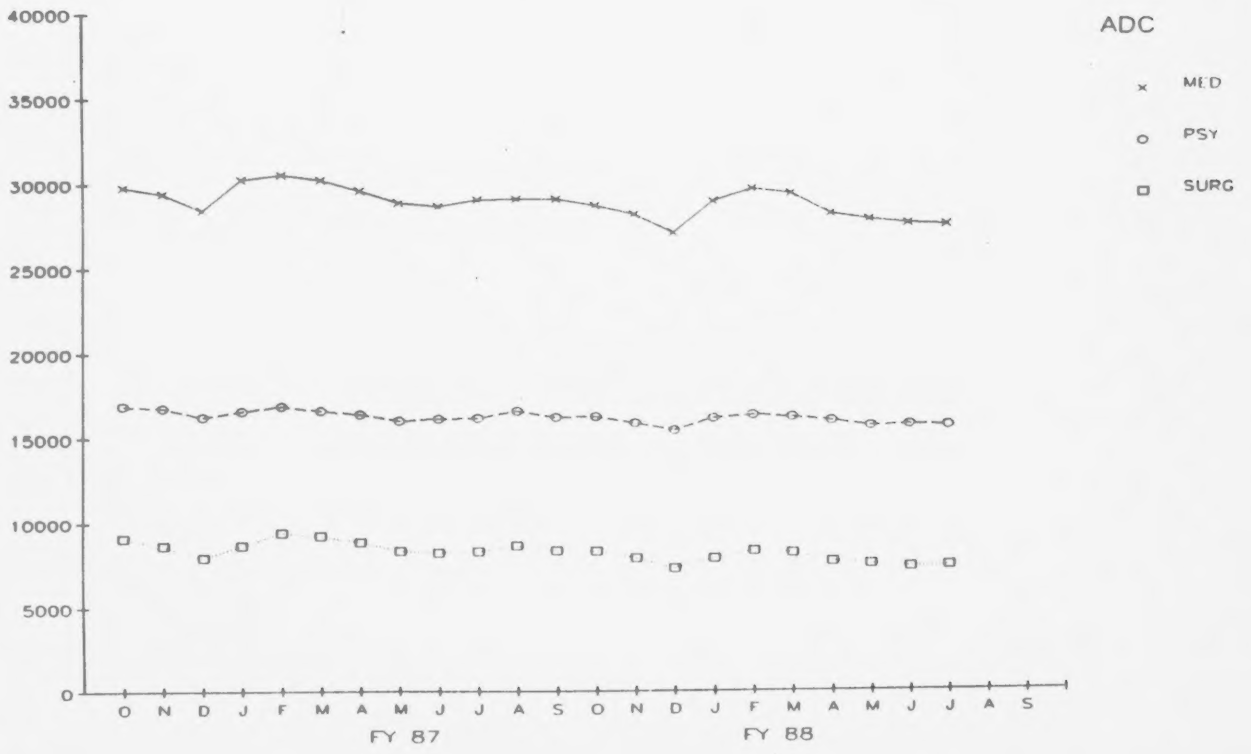


Chart 5

BED OCCUPANCY RATE BY BED TYPE
VA HOSPITALS

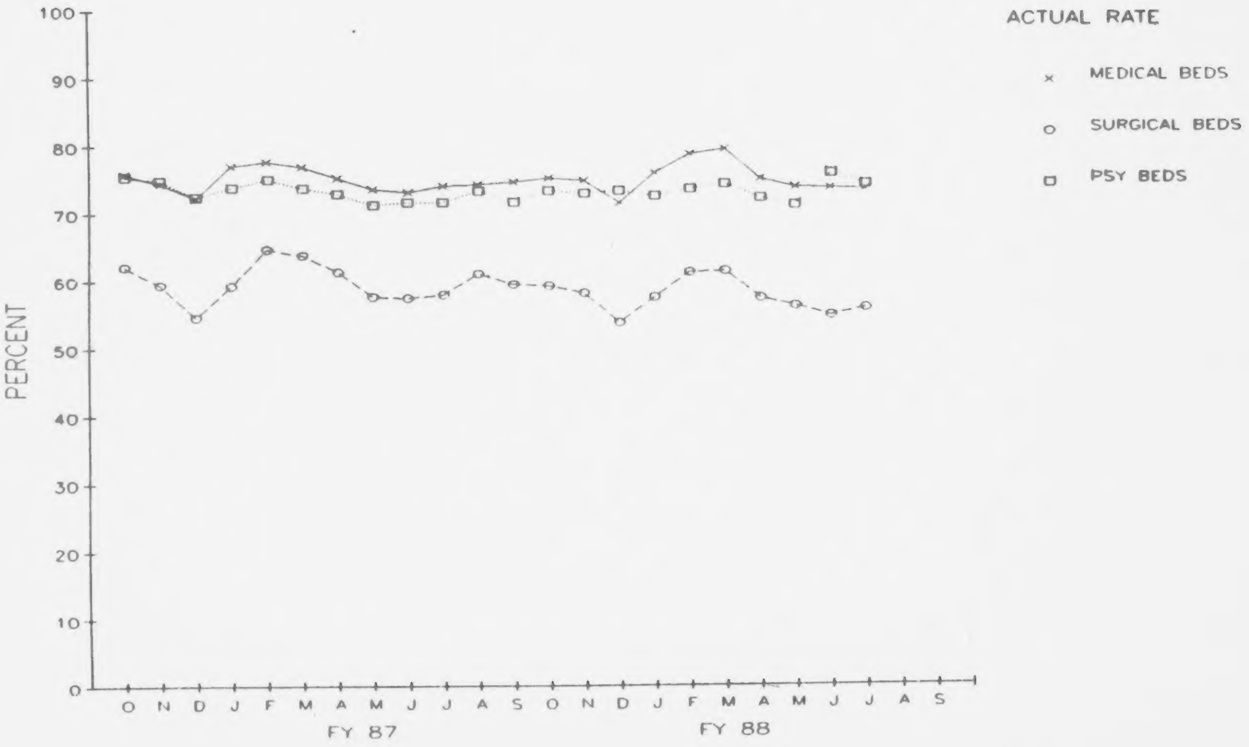


Chart 6

PATIENTS DISCHARGED BY BED TYPE
VA HOSPITALS

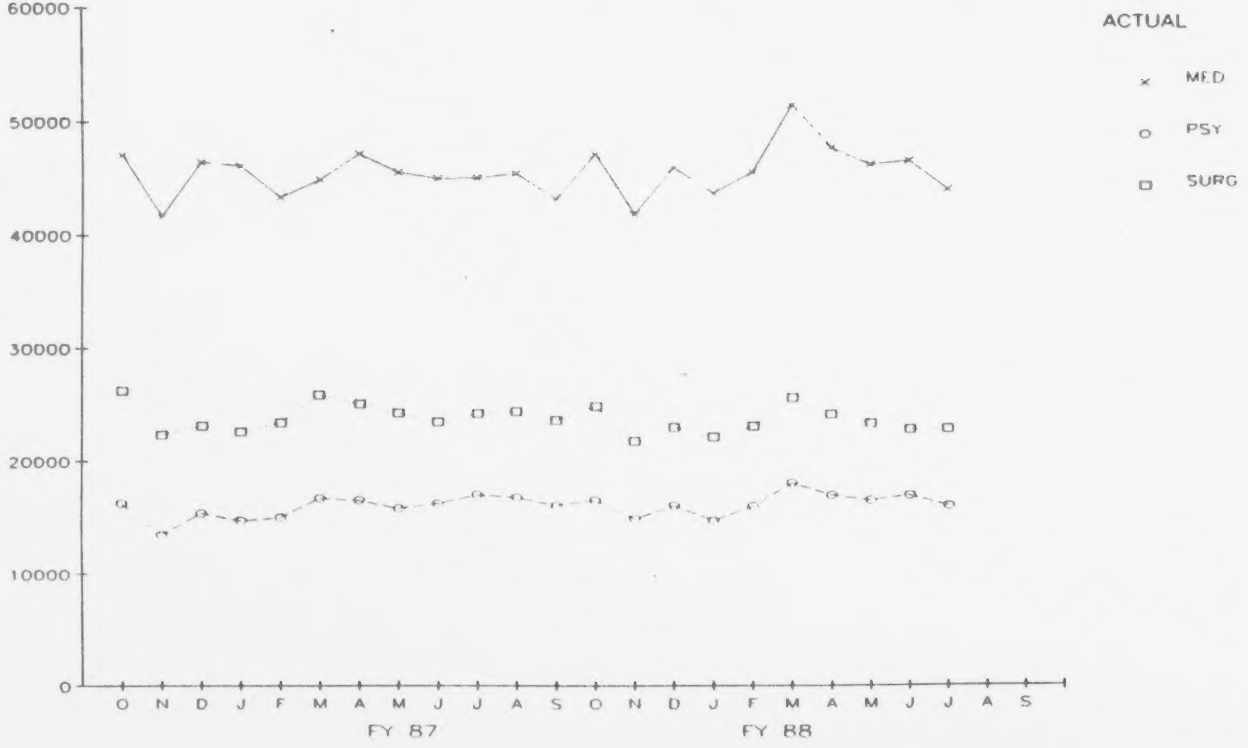


Chart 7

OPERATING BEDS BY BED TYPE
VA HOSPITALS

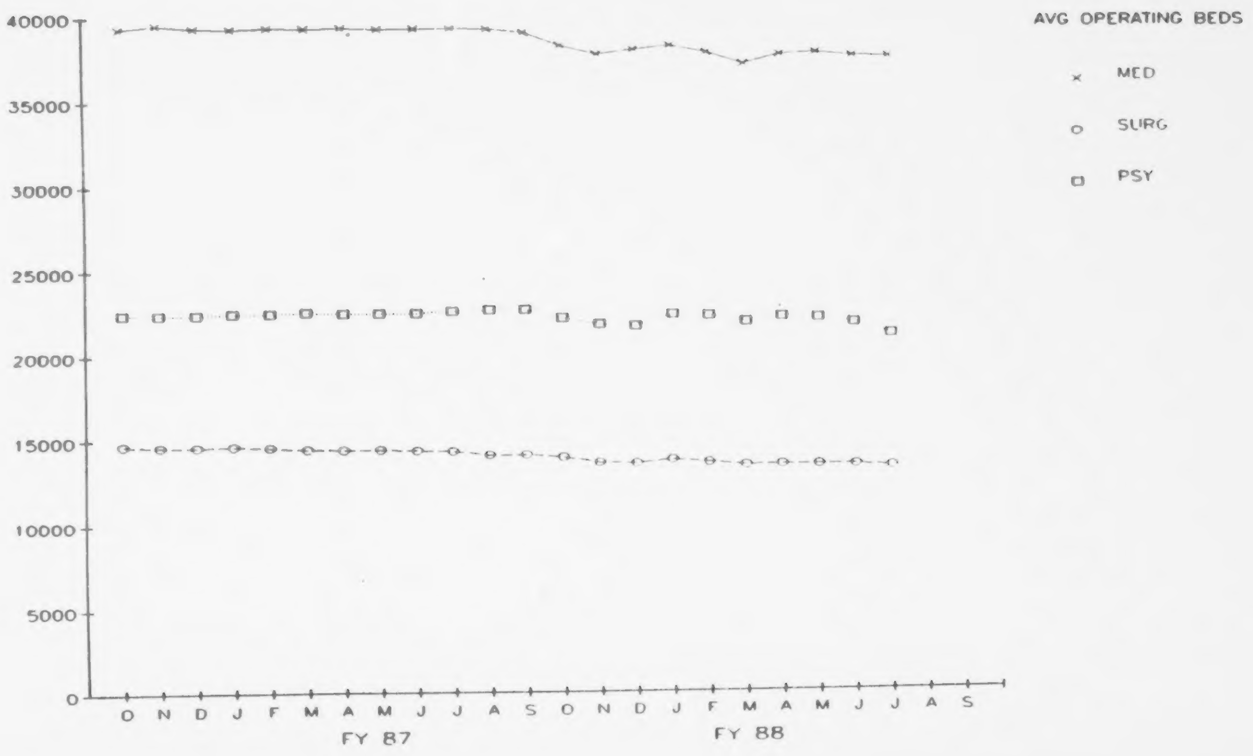


Chart 8

PATIENTS DISCHARGED NURSING HOME CARE

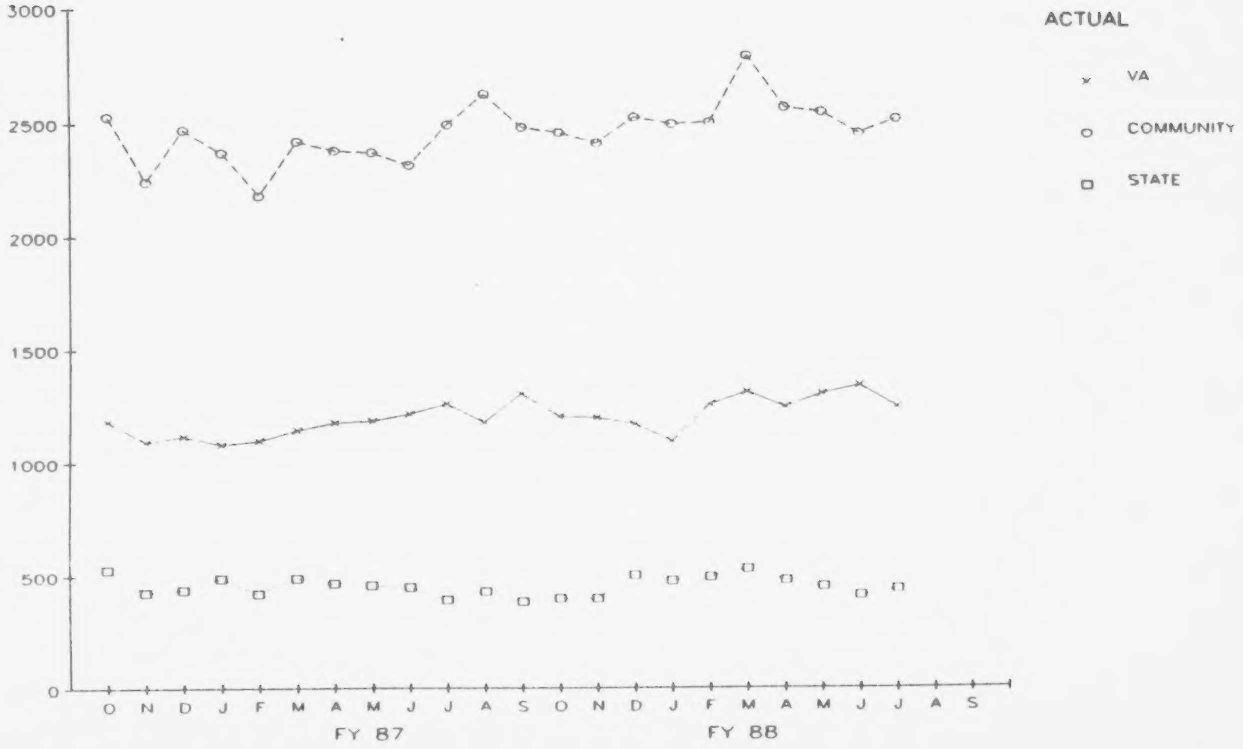


Chart 9

AVERAGE DAILY CENSUS
NURSING HOME CARE

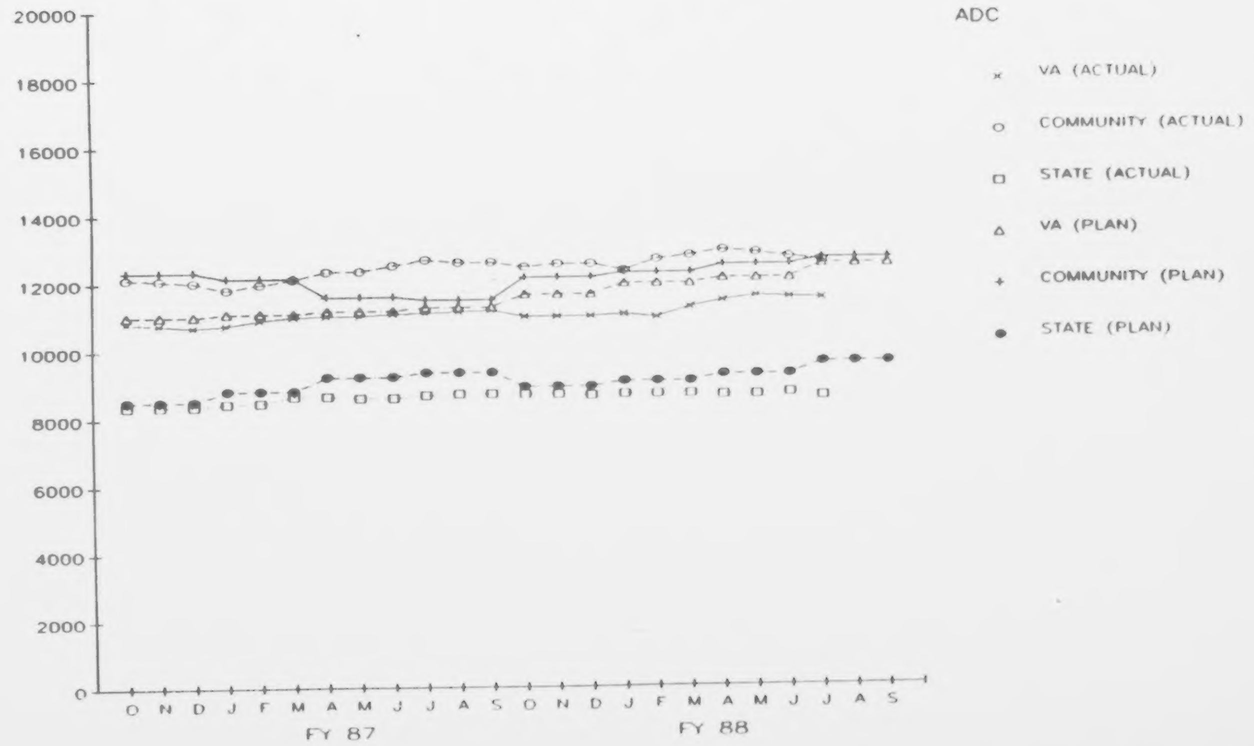


Chart 10

PATIENTS DISCHARGED
DOMICILIARY CARE

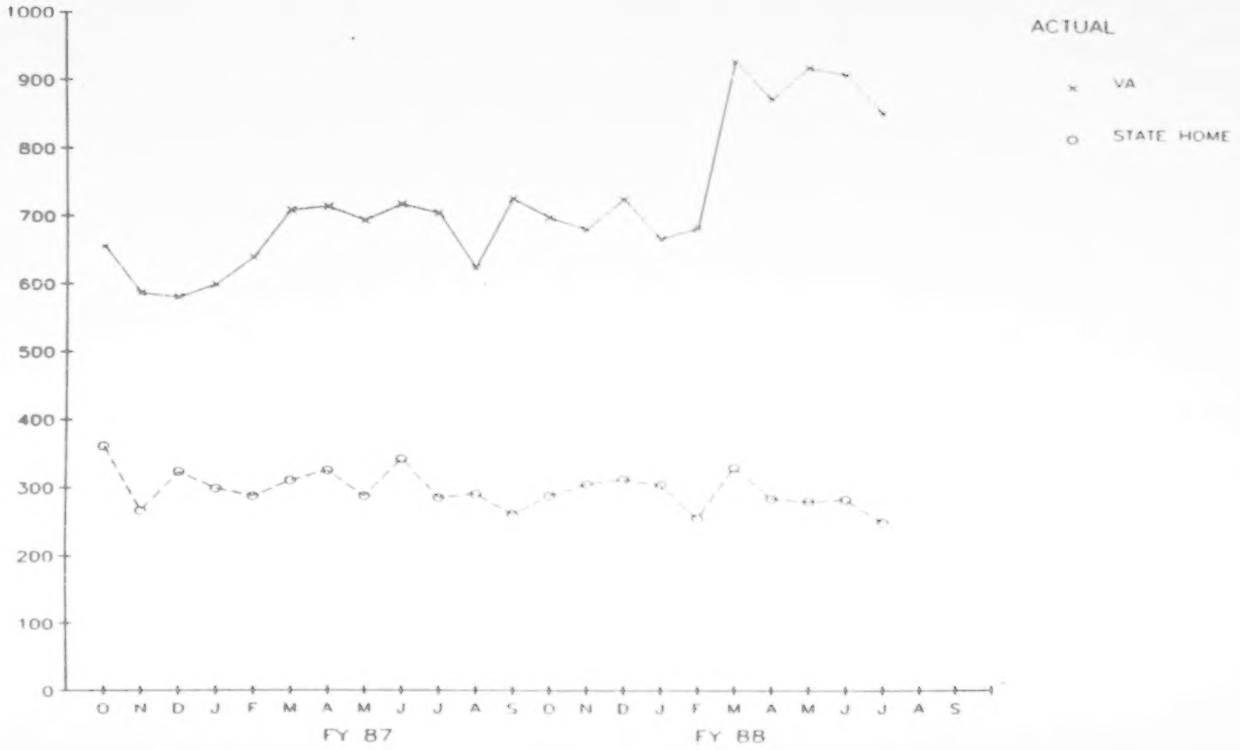


Chart 11

AVERAGE DAILY CENSUS
DOMICILIARY CARE

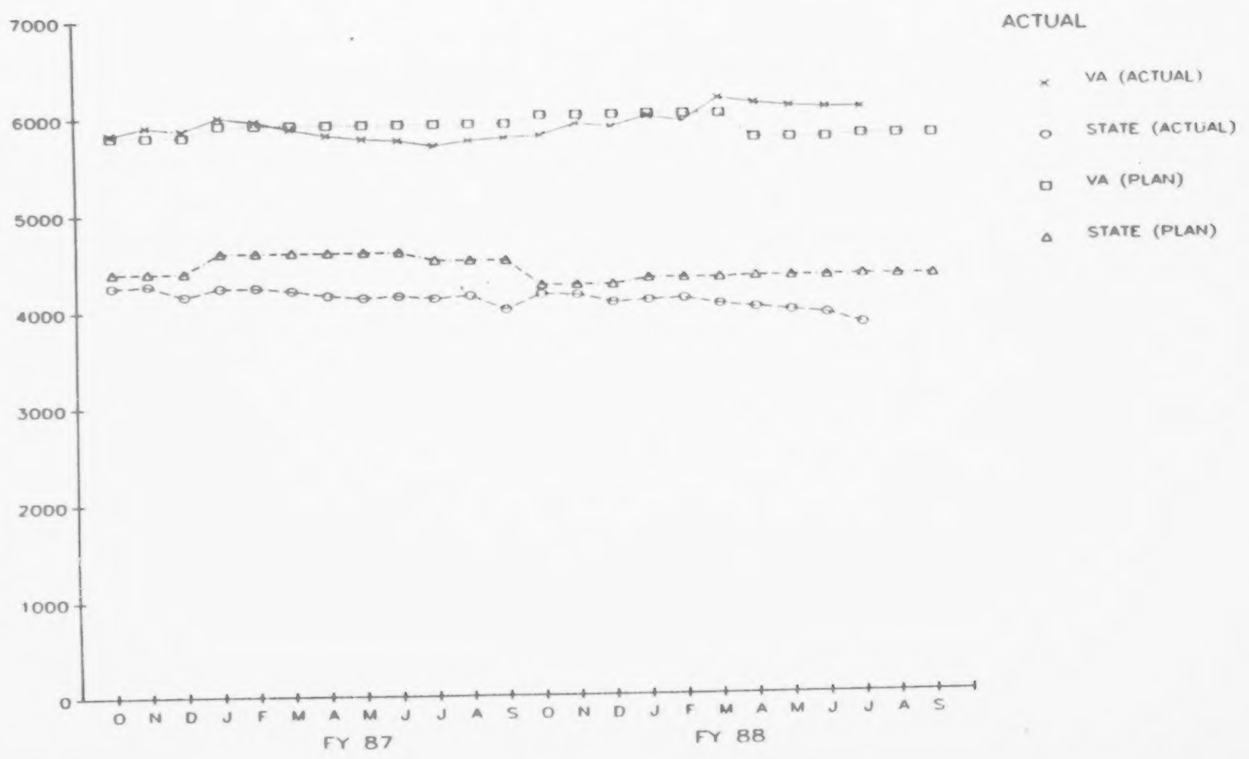


Chart 12

PATIENTS DISCHARGED
NON-VA HOSPITAL CARE

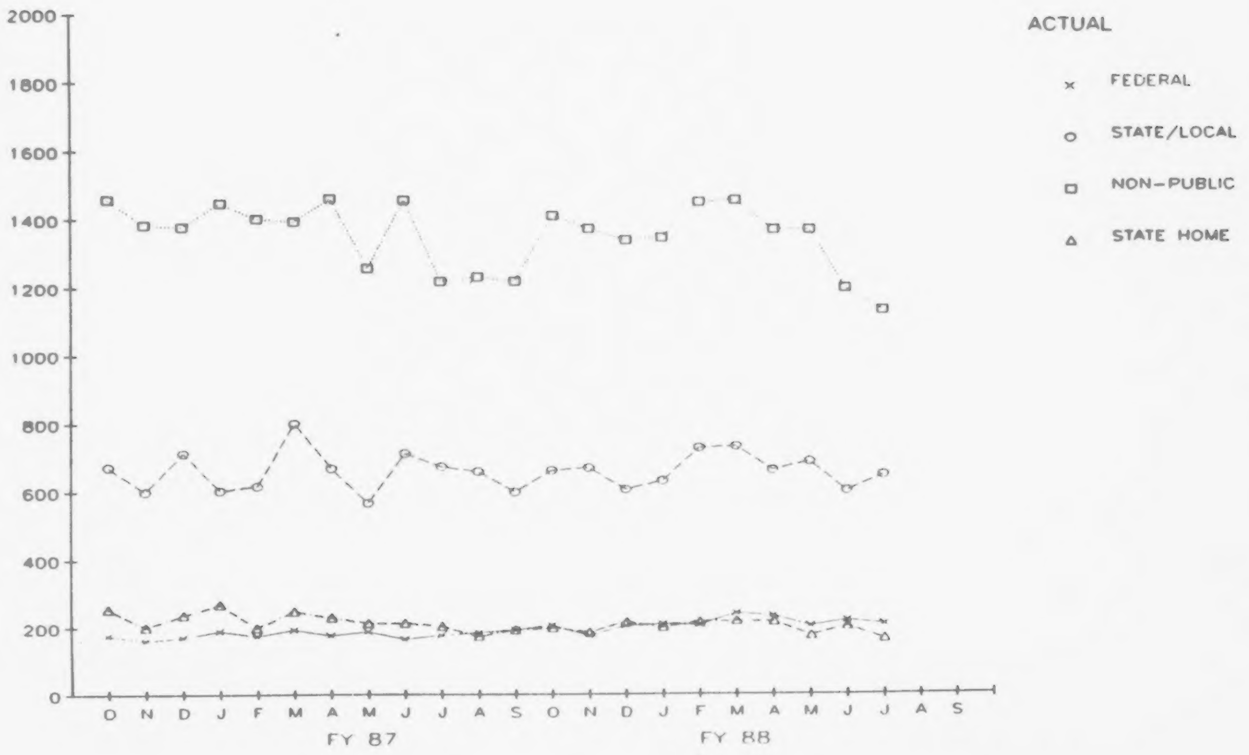


Chart 13

AVERAGE DAILY CENSUS NON–VA HOSPITAL CARE

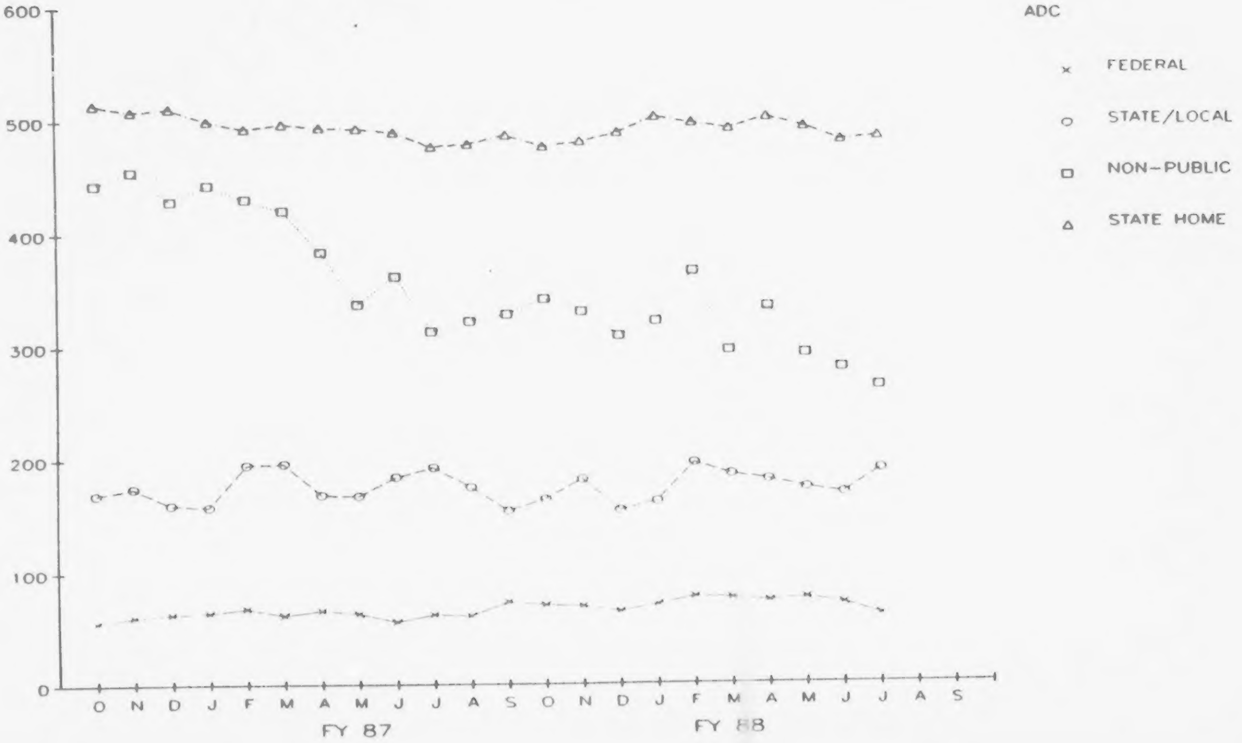


Chart 14

VISITS TO VA STAFF OUTPATIENT MEDICAL CARE

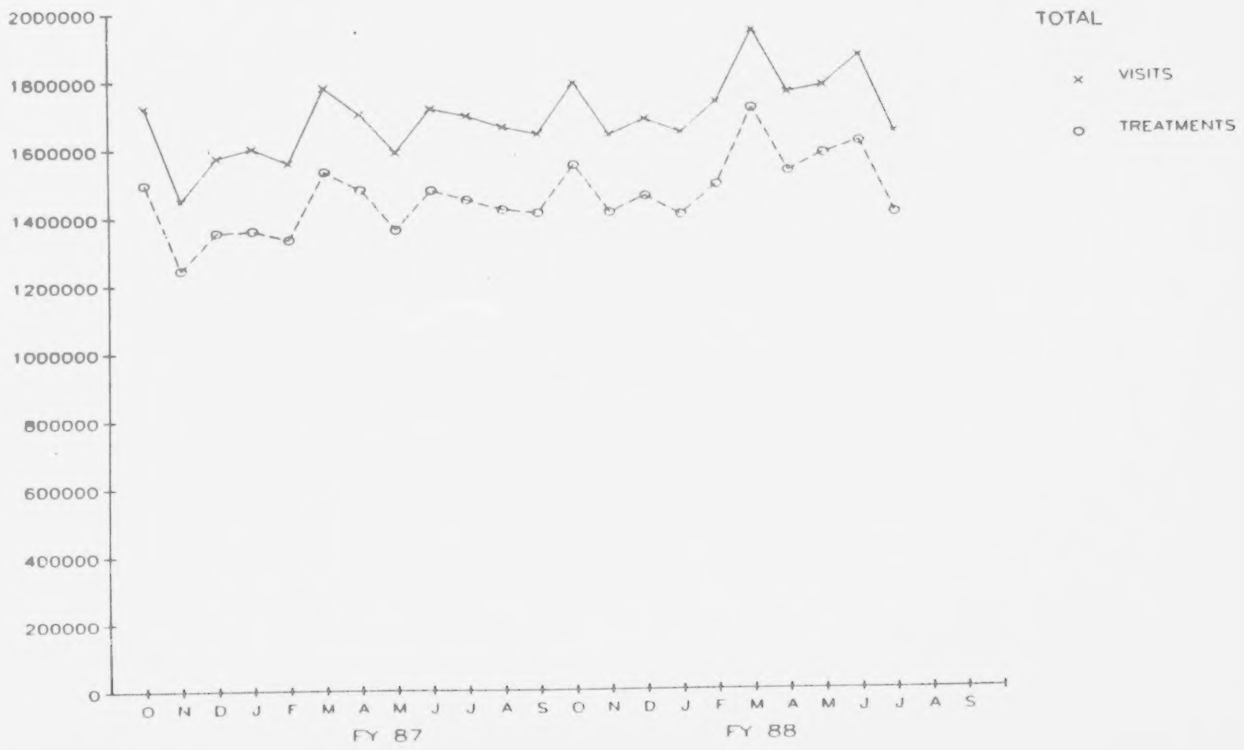
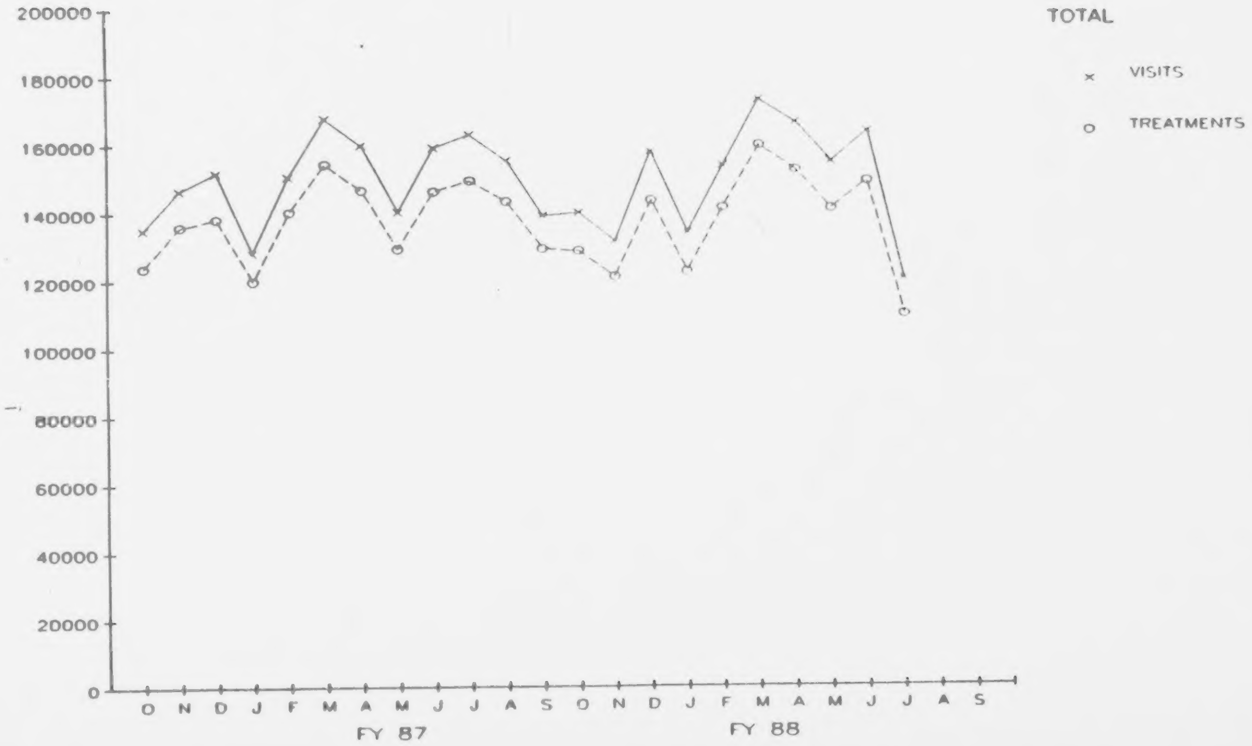


Chart 15

FEE BASIS VISITS
OUTPATIENT MEDICAL CARE



Statement of

JOHN A. GRONVALL, M.D.
CHIEF MEDICAL DIRECTOR

DEPARTMENT OF MEDICINE AND SURGERY
VETERANS ADMINISTRATION

BEFORE THE COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE

SEPTEMBER 9, 1988

It is a pleasure to have the opportunity to appear before the Committee to expand on the statement of the Administrator regarding the status of the Department of Medicine and Surgery's programs and budget. I will summarize the recent program and budget history of the Department to create a frame of reference for understanding the current status of the Department in the final months of Fiscal Year 1988 and the projections for Fiscal Year 1989.

DECADE OF COST CONSCIOUSNESS

The past decade can accurately be characterized as a decade of cost consciousness. Not only the Veterans Administration's health care system, but the entire health industry of the United States has been primarily concerned with the escalating cost of health care and the search for mechanisms to contain costs while improving productivity. In this regard, the accomplishments of the Department of Medicine and Surgery must be viewed as a record of outstanding success.

The DM&S accomplishments are particularly apparent when the productivity record of the Department is compared to the remainder of the American hospital system. Since 1979, VA has increased the number of veterans admitted to VA hospitals and, in addition, has expanded the number of veterans admitted to VA nursing homes, domiciliaries and, on a contract basis, admissions to comparable community and state facilities. This increasing amount of institutional care, either delivered by or financed by the VA, is portrayed in Figure 1.

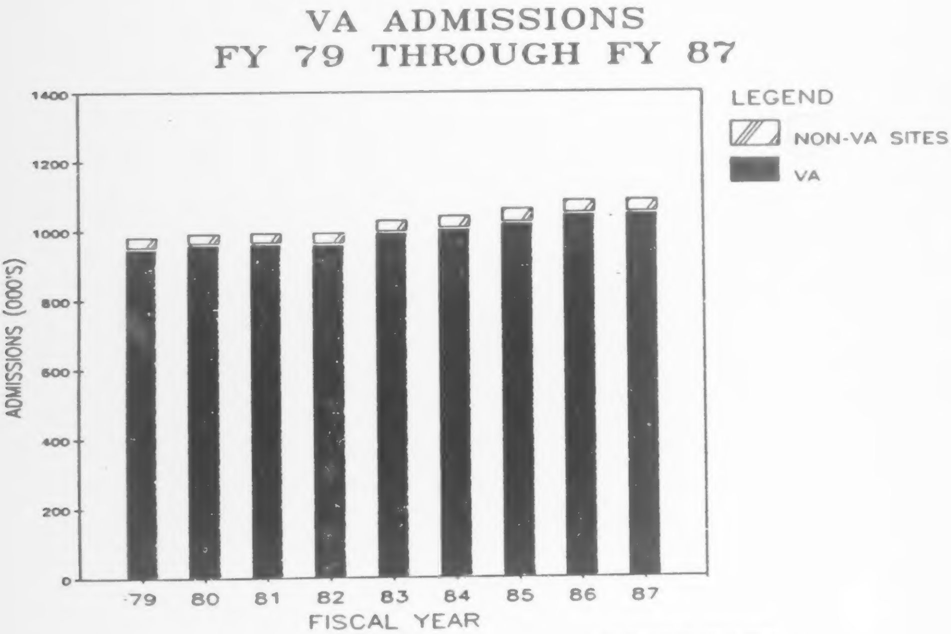


FIGURE 1

* EXCLUDES DIALYSIS

In addition, during this period VA has markedly expanded the number of outpatient visits provided. (Figure 2)

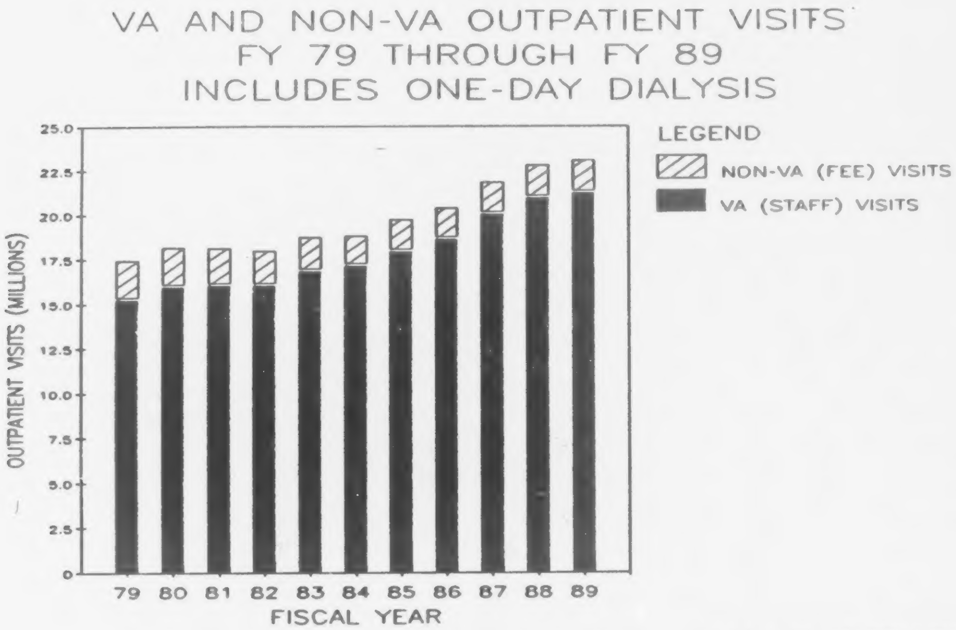
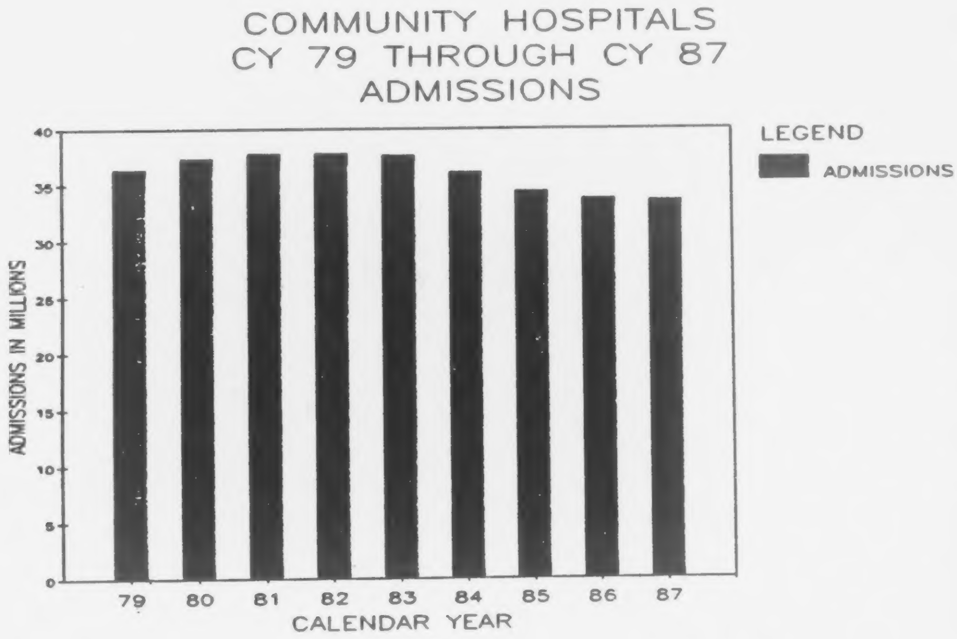

VA AND NON-VA OUTPATIENT VISITS
FY 79 THROUGH FY 89
INCLUDES ONE-DAY DIALYSIS

FIGURE 2

FY 88 & 89 ARE ESTIMATED

If the VA Medical Care Appropriation is viewed on an adjusted basis, taking into account federal salary increases and medical care cost inflation, the purchasing power of the appropriation during this decade has been essentially level. Thus, the VA has significantly expanded its capacity to deliver medical care on the basis of stable appropriation support.

The American Hospital Association has published data from the National Hospital Panel Survey since 1963. Therefore, data from more than 5,600 community hospitals (all non-federal, acute care hospitals, including university hospitals) can be compared to VA for this period starting in 1979. Early in the decade, community hospital admissions increased very slightly. However, since 1983, admissions to community hospitals have declined at a significant rate. (Figure 3)



COMMUNITY HOSPITALS
CY 79 THROUGH CY 87
ADMISSIONS

FIGURE 3

Outpatient visits provided by community hospitals have increased at a rate comparable to the VA experience. (Figure 4)

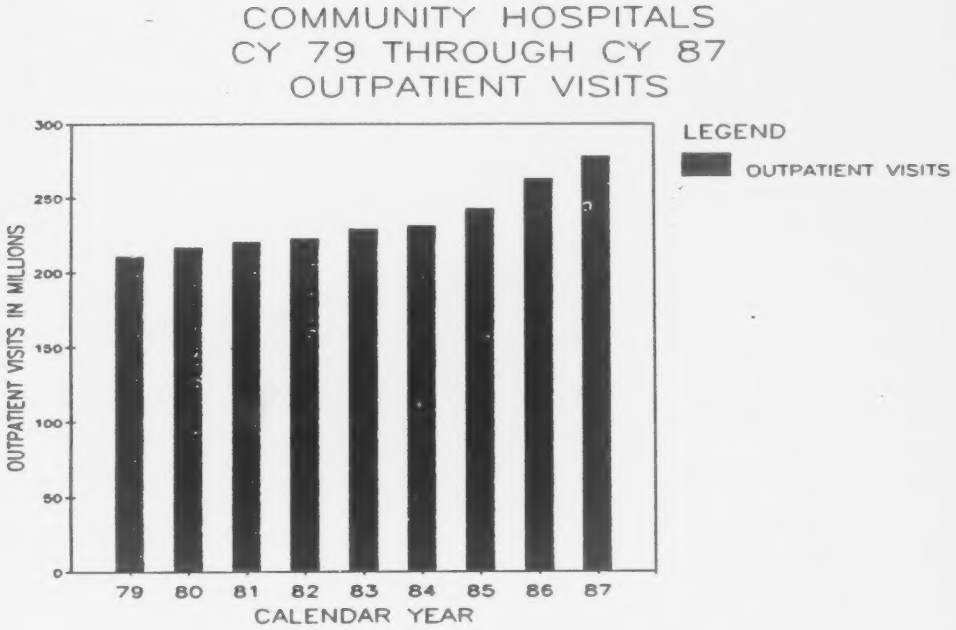


Figure 4

However, when the aggregate cost of operating community hospitals is reviewed, it is apparent that the community hospital sector has experienced an increased real cost of some 20 percent, adjusted for inflation. (Figure 5)

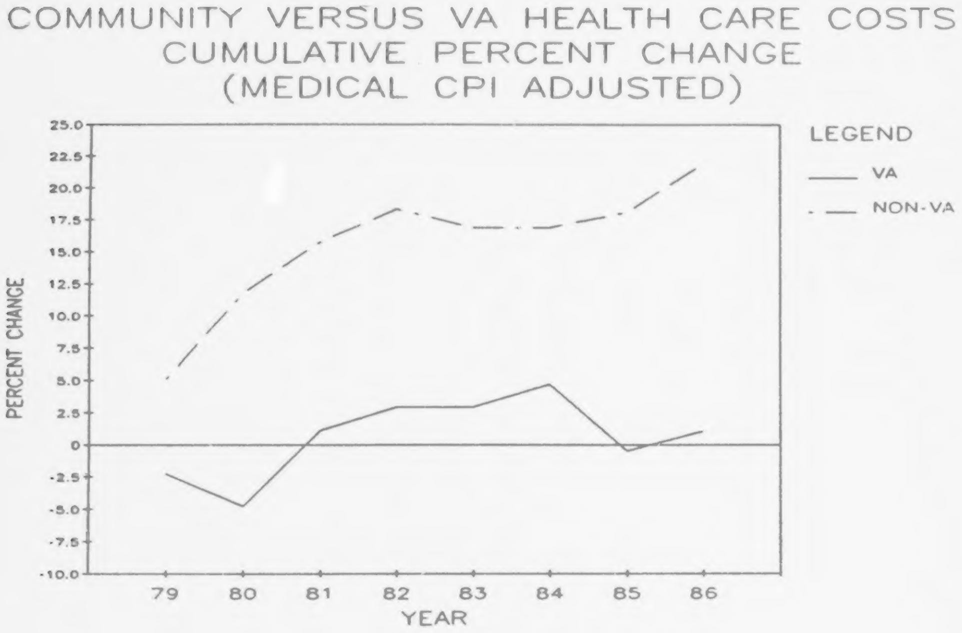


Figure 5

In summary then, during the past decade community hospitals have had a declining number of hospital admissions with increased outpatient care and a 20 percent real increase in cost. The VA, by contrast, has been able to accomplish an increase in both inpatient and outpatient care with no real increase in cost to the tax payers.

The Veterans Administration believes that this major emphasis by DM&S during the past decade on expanding productivity in order to extend the amount of care delivered to veterans has constituted sound public policy. This accomplishment has, in fact, this year been formally recognized by presentation to the Department of Medicine and Surgery of a special award from the President's Council on Management Improvement, one of a small number of such awards given after government-wide review of program productivity.

The Department of Medicine and Surgery has accomplished this enviable record by adopting a number of management approaches and budgetary incentives focused on productivity. It is the policy of the VA to operate and maintain a sufficient number of beds to meet the needs of veterans applying for admission and found to be in need of hospital care or medical services and to maintain additional beds as necessary for contingency purposes.

38 U.S.C. 5010 sets the minimum number at 90,000 combined hospital and nursing home beds. At the time legislation was passed setting this floor, it was appropriate for the VA to operate at that level. Since that time, patterns of patient care have changed and lengths of stay have decreased. We now can serve the same number of patients in fewer beds. The VA hospital bed occupancy rate in Fiscal Year 1987 was 71 percent, while the private sector operated at 63 percent for community beds. The current VA occupancy rate is 73 percent. The level used in planning for the future is a more efficient and cost effective level of 85 percent which can be achieved by reducing the level of operating beds while maintaining the level of patients treated. Ultimately the appropriate age-adjusted level of needed beds will be dictated by patient demand, acuity of patients treated, and availability of staff to provide high quality and cost effective care.

Our demonstrated ability to treat more veterans this year has been accomplished despite certain difficulties. At the close of Fiscal Year 1987, as a result of the nursing shortage, 1,890 hospital beds across the system were closed. As of June 30 this year, over 2,400 beds were closed for this reason. In spite of this, the most recent report of hospital patients treated showed that the department has actually treated 4.4 percent more patients than had been predicted in the Fiscal Year 1988 operating plan.

An additional contribution to both the quality of care and productivity has been the major emphasis on expanding care on an outpatient basis so that many procedures or conditions previously treated only in the hospital are now cared for on an ambulatory basis. The Department's Resource Allocation Model (RAM), now in its fourth year of implementation, has provided a powerful budgetary incentive for hospitals to control costs while expanding the amount of care given to veterans. During this period of increasing productivity, quality assurance reviews have been strengthened in order to avoid the possibility that individual patients would be short-changed in terms of quality as a way to achieve expanded productivity or quantity of care delivered.

It has been observed that "today's problems are often the result of the solutions designed to respond to yesterday's problems." In this regard, we believe that the Department of Medicine and Surgery is fully deserving of the public recognition which has been given to it for improved patient care productivity. As a result however, we at some point will be in a position of limited opportunity to make further internal expansions of productivity. Externally-mandated floors, ceilings, and other restrictions, however, have limited the Department's management flexibility.

FISCAL YEAR 1988--A WATERSHED YEAR

Several unique and major factors make the current year, Fiscal Year 1988, a watershed year for the Department of Medicine and Surgery. The "budget summit agreement", already referred to by the Administrator, established a clear mandate that the Department must operate within the resources provided in the initial appropriation, with a prohibition against seeking supplemental funding. The Department of Medicine and Surgery viewed this mandate with extraordinary seriousness, and planned its internal operation in such a way that we would do our share to contribute to the fiscal stability of the nation. Early in the second quarter of the year, a set of budget adjustments were made internal to the Department with this understanding in mind. VA medical center directors were given their "marching orders" with the allocation of funds for the remainder of the year. On this basis, I have continued to assure the Administrator, and I here today repeat that assurance to the Congress, that we have continued throughout this year to meet our responsibility to provide care to all veteran applicants who, by statute, "shall" be furnished VA care.

Several other unique phenomena have also impacted the Department's operations during this current year. The national shortage of nurses and other critical health professionals has required an array of responses to enable the Department to continue to ensure the availability of appropriate personnel for health care delivery. The nurse shortage is fundamentally a supply problem.

The available pool is shrinking and, faced with more lucrative options, nurses are leaving the profession. In some geographic areas, the VA finds it difficult to meet its need for nurses. However, while the nursing shortage in the private sector is 11 percent, VA's nursing shortage is approximately 4.6 percent.

To assist in encouraging talented men and women to remain in or to enter the nursing occupation, DM&S is addressing the disincentives common to the nursing occupation and those peculiar to the VA and/or Federal service. Specifically, the VA is seeking ways to improve the commonly accepted occupational deterrents, including undesirable working conditions, poor salary and benefits, and the lack of professional autonomy. To this end, the following initiatives are underway:

- establishment of a Program Office within DM&S to give national focus to recruitment and retention efforts/concerns and to serve as an information clearinghouse;

- provision of needed special salaries; and,

- enhancement of the VA's image as a health care employer, providing on-site child care facilities, and enhanced ADP capabilities.

These initiatives are designed to provide assistance to all of the occupations experiencing shortages. However, it must be noted that these initiatives as well as others already in place, such as special salary rates and Saturday premium pay, require significant funding. Special salary rates have now reached a level in excess of $100 million. Funds for these purposes have come from internal reallocations within the Department's operations and the need for additional funding has been recognized by the Congress with the $45 million for special pay in the Fiscal Year 1989 Appropriation. In addition, the expanding number of AIDS cases in the VA has created additional stress both in terms of resource needs and the additional demands on health care workers who must now take universal precautions to treat all blood and body fluids as though potentially infected.

The recently enacted Fiscal Year 1988 supplemental appropriation of $31.7 million allows relief for implementation of Public Law 100-322; which, with several mandatory provisions requiring implementation this fiscal year, had further stressed limited resources. Prior to receiving the supplemental appropriation, the Department had internally re-allocated resources from activation funds, nonrecurring maintenance funds and equipment accounts to provide for implementation of Saturday premium pay, expanded beneficiary travel, increased state home per diem rates, and expanded outpatient medical care eligibility. This fact was reported to the Congress by letter on July 6, 1988.

FISCAL YEAR 1989 OUTLOOK

The Department of Medicine and Surgery is engaging in an intensive, formal, in-depth review of the status of its programs and operations in the context of the mandates contained in Public Law 100-322 and the Fiscal Year 1989 Appropriation. The largest single source of uncertainty in predicting the state of the Department's operation for Fiscal Year 1989 relates to this newly-enacted legislation (P.L. 100-322). We estimate that implementation of the mandatory provisions in this statute may, during Fiscal Year 1989, require up to $117 million. I must emphasize that this estimate has not yet been subject to complete review and is not currently a part of the Administration's program.

Additional funds might also be needed for special pay rates to assure retention of critical personnel. Further, based on the Fiscal Year 1989 Appropriation, the Department will be required to absorb 2.1 percent of the projected 4.1 percent federal pay raise. This will require an internal reallocation of over approximately $86 million.

Because of the size and impact of these requirements on the coming year's operating budget, the Department is engaged in an intensive planning effort. This has involved the development of a comprehensive statement of all of the elements in the Department's operating budget which are not provided for in the Appropriation, but which may need to be accommodated in Fiscal Year 1989 operations.

These requirements are the result of new authority in P.L. 100-322; internally-identified needs to accommodate essential Departmental activities (such as special pay); requirements to meet mandates of Congress expressed in the Appropriations law; and a substantial increase in Federal Employee Health Benefit costs.

Our process of identifying potential problems includes consultation with the Field Advisory Council (a major advisory body for the Chief Medical Director), the Assistant Chief Medical Directors (the key program officials in the Central Office), and the potential problems were also the subject of detailed review during a series of regional meetings in July 1988 with all of the Regional Directors, Medical Center Directors and Chiefs of Staff. A list of management options has been developed to create the broadest possible array of steps which the Department might take in order to harmonize program commitments with the Fiscal Year 1989 Appropriation. These management options were subjected to intensive review by a small Departmental task force during a 3-day meeting concluded on July 28, 1988, and we are now considering the Task Force recommendations. Several options being considered can be briefly described.

1. Establishment of workload controls. The Department is considering establishing prospective management controls on the quality of care delivered by VA medical centers, consistent with statutory requirements, to ensure that quality of care is protected.

2. Elimination of over-the-counter drugs now provided to veterans during outpatient visits and potential limits on providing drugs to veterans other than those who, by statute, "shall" be furnished VA care.

3. Decentralization of non-VA workload accounts, to maximize VAMC control of decisions regarding the most effective way to provide needed care.

4. Rigorous review of medical center missions with particular focus on program and management consolidations based on changing demographic needs and changing medical care delivery capabilities.

THE DECADE AHEAD-THE DECADE OF QUALITY

There is clear evidence that the country is now focusing increasing attention on the issue of quality of care and the resource implications of various quality measures. While cost considerations continue, this highly focused public concern about quality is joining the concern about costs as a major force behind health care system decisions. The first national steps have been taken to attempt a useful definition of "quality", and a quantitative approach to the identification of quality. This will allow more effective correction of deficiencies when inadequate quality is identified. The Veterans Administration has been and is committed to maintaining a leadership role in health care quality assurance activities. The review several years ago of each of the VA open heart surgery programs has been pointed to by health experts outside the VA as one of the most systematic reviews of quality followed by effective action in any health system. Specific legislation has been implemented (P.L. 99-166) mandating a review of VA surgical mortality, and more recently the VA has self-initiated a comprehensive review of mortality experience in all VAMCs in order to test the usefulness of mortality analysis as a measure of quality of care. This review is still in process, but a recent General Accounting Office report was complimentary of the review methodology being used by the VA.

While these first steps of the health care system toward a useful measurement of quality may be faltering ones, they are extraordinarily important in order to assure the public that our hospitals are concerned not only with quantity and cost of care, but with the quality of care available to every individual veteran patient. The Department has regularly stated its public commitment that quality of care will be protected. These steps to validate quality measures will allow the Department to deliver on that commitment.

FISCAL YEAR 1989 - THE POLICY DECISIONS

The Department of Medicine and Surgery looks forward to the opportunity provided by this oversight hearing to clarify the current status of the Department's commitment to quality care for veterans, and to highlight the management options now being considered. This hearing places into the forum of public deliberation these major policy issues regarding the future evolution of VA medical care. The hearing can thus serve as a preamble to a more regular process of public deliberations on these issues which will occur as a result of the impending elevation of the VA to the Cabinet. We believe the Department is responsibly facing the challenge of documenting the potential impact of the Fiscal Year 1989 Appropriation in the context of new and expanding statutory requirements. We have developed a set of management options designed to ensure that the Department will take responsive action to continue the delivery of quality care to America's veterans.

We will be pleased to respond to questions that the Committee may have.

United States Senate

COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510-6375

September 13, 1988

Honorable Thomas K. Turnage
Administrator of Veterans' Affairs
810 Vermont Avenue
Washington, D.C. 20420

Dear Tom,

I am writing in connection with your promise at the Committee's September 9 oversight hearing to do everything within your power, including appealing to the President if that's what is necessary, to obtain timely Administration action on a fiscal year 1989 supplemental request dealing with the projected shortfall in the VA's medical care account.

I wish to emphasize two vitally important matters in this regard: First, that the amount you ask to be included in such a request be sufficient to enable the VA in FY 1989 to maintain its current levels of services and comply with all applicable laws; and, second, that your actions be most expeditious in order to produce an Administration request that can be considered by the House Appropriations Committee when it marks up an FY 1989 continuing resolution.

As to the amount of the request, I would underscore the testimony of the Chief Medical Director (CMD), Dr. John Gronvall, that an additional appropriation of $608 million is necessary for this purpose. Otherwise, depending on the amount of the shortfall, the VA would be forced to take a number of actions -- such as those described in the CMD's August 4, 1988, Task Force Report on the FY 1989 Budget -- to cut back on health-care services to veterans. For example, if you are seeking additional funding for the purpose of covering only the FY 1989 costs of implementing the mandatory provisions of Public Law 100-322, estimated at $117 million, you need to increase your request substantially in order to avoid serious cutbacks in VA health care.

Regarding the timing of your actions, you will recall that the issue of the length of time needed to obtain Office of Management and Budget (OMB) approval of supplemental requests was raised during the hearing. At the hearing, Gary Cole, the VA's Deputy Controller, stated that the VA's supplemental request for FY 1988 (in connection with Public Law 100-322) was submitted to OMB in May 1988 but was not acted upon (rejected) until August 3. Based upon that lengthy OMB processing time, I am concerned that your FY 1989 request will not be reviewed and approved swiftly, and I therefore believe it is imperative that you closely monitor the progress of your request and take all actions you believe are necessary to obtain a prompt and favorable response.

In this regard, I would note that in order for an FY 1989 VA supplemental request to be enacted during this Congress, which is expected to adjourn before or during the second week of October, OMB must send the request forward and must do so in the very near future. I think it is highly unlikely that in the absence of such a request Congress will act to provide the VA with additional medical care account funds for FY 1989 -- as it did for FY 1988 as a result of my amendment on August 4. It is expected that the House Appropriations Committee will consider an FY 1989 continuing resolution before September 23. Unless that Committee has received before then a formal request for the funding and the request is in a sufficient amount, there will be very little chance that adequate funds will be made available in time to prevent substantial reductions in VA health care. The next opportunity for the Congress to consider such an action would be in late January, after the 101st Congress has convened. That would mean that it would be impossible for supplemental appropriations to be enacted until at least four months of FY 1989 had passed and drastic reductions in services would have been made based on the assumption -- the only safe one that could be made under the circumstances -- that no additional funds will be appropriated.

Tom, I am sure you must have been deeply impressed, as I was, by the gravity of the situation as portrayed at our Committee's September 9 hearing by the service organizations' representatives and VA field and regional staff, all of whom testified under oath that the current situation is the worst fiscal crunch for VA medical facilities that they had ever seen. Thus, I urge that you take all action necessary to obtain the funding necessary to maintain safe and appropriate health care for our Nation's veterans in the coming fiscal year, and I would greatly appreciate your keeping me closely advised of your actions in this regard.

With warm regards,

Cordially,

Alan Cranston
Chairman

cc: Honorable Frank Murkowski
Honorable Dennis DeConcini
Honorable Sonny Montgomery

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES
Affiliated with AFL-CIO
80 F Street, N.W., Washington, D.C. 20001

STATEMENT OF

JOHN N. STURDIVANT
NATIONAL PRESIDENT
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES
(AFL-CIO)

SUBMITTED TO THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
100TH CONGRESS, SECOND SESSION

ON

THE ADEQUACY OF VA RESOURCES, FUNDING, AND THE RECRUITMENT AND RETENTION OF QUALIFIED HEALTH CARE WORKERS

SEPTEMBER 9, 1988

My name is John Sturdivant. I am the National President of the American Federation of Government Employees (AFGE), AFL-CIO. We represent some 700,000 federal employees nationwide, including 19,000 professional and 102,000 non-professional employees in the Veterans Administration (VA).

In my discussions with VA workers across this country, I have found the following statements to be true for VA health care workers in every occupation and profession, in VA facilities of every size:

-- Morale is at an all-time low.

-- Employees are overworked and underpaid.

-- Job-related stress is bad and getting worse.

-- All too often management seems indifferent to the VA's mission.

The bottom line for these workers is that dedication, commitment and plain old-fashioned hard work can relieve only a small amount of the desperation these employees feel about their working conditions and the impact those conditions have on veterans care.

I know I speak for every VA employee when I say that the care and well-being of the men and women who served our nation are in jeopardy each day these conditions are permitted to continue unabated.

On behalf of VA employees, I urge this Committee to do everything in its power to alleviate this current crisis by restoring the necessary funding and resources to the Veterans Administration.

Perhaps the most telling statistic revealing the extent of the overall personnel crisis is the separation rate for the VA. In FY 1987, 27.76% of the VA employees -- 68,361 employees -- left the VA for other employment or retirement. That rate of 27.76% was higher than any cabinet level Department except the Department of Agriculture, and it was 47% higher than the average rate for executive departments.

This astonishing separation rate shows no signs of diminishing. Through the first eight months of this fiscal year the VA's turnover rate was 16.01%, which projects to a 24% annual rate. (Source: Federal Civilian Workforce Statistics Employment and Trends, September 1987 and May 1988.)

These turnover numbers mean that every four years it is as though the VA has an entirely new workforce. So it is difficult to see how Administrator Turnage can claim that the VA "get(s) all we need to do our job well" (Washington Post, August 31, 1988) when he cannot recruit and retain the personnel he needs to get the job done.

A more detailed examination of these aggregate numbers is equally disturbing. I have attached these statistics, by occupation, as an addendum to this testimony.

Nonetheless, these cold sterile statistics cannot fully explain the anguish of the employees charged with making life and death decisions every hour of their work day. These numbers cannot tell how many veterans have had to wait for care, or how many have had to go without needed words of comfort and encouragement because a VA employee was forced to rush to another patient's bedside. We will never hear from these statistics about the nurse in the Minneapolis VA Medical Center who says she "prays I don't goof" as she hurries from one crisis to another. Finally, the numbers do not show the danger VA employees constantly face when even a single, accidental needle stick can lead to a dreadful incurable disease.

Further, in the area of direct care to veterans our members express great concern over the new Resource Allocation Management (RAM) System. In particular, the use of rigid predetermined treatment times for particular illnesses or injuries (similar to Diagnostic Related Groups (DRGs) in the health insurance field) is causing problems. Our members report that in all too many individual cases, veterans are being released from the medical centers to meet the predetermined schedules rather than meeting the health needs of the individual veterans. We urge the Committee to maintain close oversight of the implementation of RAM.

We want to bring to the Committee's attention two other recent actions which are disrupting VA personnel relations and are having a serious adverse impact on VA's ability to recruit and retain needed personnel.

By far the most serious action is the decision in the Court of Appeals which effectively strips VA Title 38 personnel from collective bargaining protection.

For many years, the Veterans Administration has negotiated over working conditions pursuant to the provisions of the Civil Service Reform Act of 1978 and entered into collective bargaining agreements with unions representing both Title 5 and Title 38 employees. The one major difference in the negotiations affecting both groups of employees has been the fact that Title 38 employees have been unable to negotiate a grievance procedure to be utilized in the case of disciplinary matters. Instead, those employees have been subjected to the disciplinary boards established pursuant to Sec. 4110 of Title 38.

Your Committee's reported bill, S. 2011, provides for the use of negotiated grievance procedures in the case of disciplinary actions involving suspensions of 14 days or less, reassignment or reduction in rank without a reduction in basic pay, reprimand, or admonishment. This would seemingly require the VA to bargain in good faith with exclusive representatives with respect to grievance procedures for lesser disciplinary matters in the same manner that other provisions affecting working conditions have historically been negotiated between the parties. However, in light of the July 19, 1988 decision of the United States Court of Appeals for the District of Columbia in the case of Colorado Nurses Association v. FLRA, grave concerns are raised not only over prospective negotiations pursuant to S. 2011 (grievance procedures for lesser disciplinary matters) but over negotiations for other proposals which have heretofore posed no problems between the VA and the exclusive representatives.

The Court found in the Colorado Nurses case that the Civil Service Reform Act did not override Section 4108 of Title 38 enacted some 34 years earlier. Rather, the Court determined that Title 38 establishes an "entirely different personnel system from that embodied in Title 5" which gives the "Administrator unfettered discretion to issue regulations concerning working conditions." On this premise, the Court concluded that although the Administrator may choose to bargain over matters affecting working conditions, he has absolutely no obligation to do so. Quite simply, the Court found that Title 38 "leaves no room for mandatory collective bargaining."

Congress has consistently maintained that collective bargaining is in the public interest and to the extent that collective bargaining is not inconsistent with the specific matters involving serious disciplinary actions, etc., the collective bargaining provision of Chapter 71, Title 5, should be applicable to those employees covered by the provisions of Title 38. But in light of the Colorado Nurses decision, without clear Congressional action, Title 38 employees can be unilaterally excluded from any collective bargaining decisions.

Our locals are reporting that for many of our Title 38 members this will be the straw that breaks the camel's back. While their commitment to the VA and veterans care has kept them on the VA staff for many years through difficult times, they are now asking why they shouldn't go "across the road" to state, local, charitable or for profit hospitals and earn more money, have less stress, get better health benefits and have the protection of a collective bargaining agreement. Have no doubt about it, without legislative redress to restore the status quo, current recruitment and retention problems will worsen.

In that regard, let me express our appreciation to the Chairman, Senator Alan Cranston, and the Ranking Minority Member, Senator Frank Murkowski, for their letter to Administrator Thomas Turnage urging that he maintain the status quo. We look forward to remedying this situation through the legislative process.

Finally, this Committee has been in the forefront of defending quality health care for U.S. veterans. As part of your commitment to veterans, this Committee and the Congress, in recognition of the severe staffing problems of Registered Nurses (RNs) in the VA, authorized 25% premium pay for Saturday work for RNs. Unintentionally, this has created a good deal of resentment among the VA personnel who are not eligible for Saturday premium pay. Workers look at pay as a return for their work and effort. Workers, especially those working side by side with RNs, legitimately ask: "Are we working less hard or sacrificing less for our Saturdays than the RNs with whom we work?" For all of these reasons, we support section 4 of H.R. 5114 which would include Nursing Assistants, Licensed Practical Nurses (LPNs), and nurses in the Saturday premium pay provision. We encourage favorable

Senate consideration of it. Ultimately, the Committee should consider applying such premium pay to all classes of employees who work similar shifts and locations.

Thank you.

Addendum
Source: 1987 Survey of Health Occupational Staff, VA
Fiscal Year 1987

*For Registered Nurses:

- The vacancy rate increased from 1.6% to 4.6%
- The turnover rate increased from 16.1% to 22.2%
- 55% of VA facilities report that vacancies were open 3 months or longer (on average)
- Only 35% of VA facilities report that VA nurses salaries were comparable to private sector salaries

*For LPNs:

- The vacancy rate increased from 8.4% to 10.6%
- The turnover rate increased from 18.9% to 30.3%
- 44% of VA facilities report that vacancies were 3 months longer (on average)
- Over 51% of VA facilities report that larger or more frequent pay increases at other medical facilities place them at a disadvantage
- Only 38% of VA facilities report that their LPNs salaries are comparable to private sector salaries

*For Nursing Assistants:

- Turnover rates increased from 16.3% to 20.1%

*For Pharmacists:

- More than 68% of VA facilities report that vacancies were, on average, 3 months or longer

- o 86% of VA facilities report that private sector salaries were higher for comparable work

*For Physical Therapists:

- o More than 90% of VA facilities report that vacancies were, on average, 3 months or longer
- o Some 78% of VA facilities report higher private sector salaries
- o Over 47% of VA facilities report using employees in other occupations to provide staffing coverage for therapists

*For Occupational Therapists:

- o The turnover rate increased from 23.4% to 26.2%
- o 80% report vacancies stay open for 3 months or longer
- o More than 68% report-higher private sector salaries

*For Certified/Registered Respiratory Therapists

- o The vacancy rate increased from 14.9% to 21.1%
- o The turnover rate increased from 21% to 24.1%
- o More than 67% report higher private sector salaries

*For Nuclear Medicine Technician/Technologists

- o Vacancy rates increased from 2.4% to 5.9%
- o Turnover rates increased from 11.5% to 18.9%
- o 64% of facilities report higher private sector salaries

I was asked to give input on employment in the Veterans Administration Nursing Service due to my 29 years experience as a VA nurse, and in my role as president of the American Federation of Government Employees Registered Nurse Local 3669 at the VAMC in Minneapolis, Minnesota.

In gathering material for this paper, I discussed nursing as a career in the VA system with many of my coworkers: the pros and cons, the reasons nurses stay or leave (both VA Nursing Service and nursing as a career.) I recalled many discussions with the RN members of this local's bargaining unit in this union's effort to represent them in solving some of their grievances, presenting these frustrations and concerns to management and negotiating to solve some of them.

We as a local have been one of the most active in the nation in attempting to aid in the recruitment and retention of nurses for the Veterans Administration Nursing Service: on the local level with management, in this five state area of union, and on the national level through nursing leadership in the VA Council of AFGE. We very actively lobby with this state's congressmen and senators, the chairmen of the House and Senate Veteran's Affairs Committees, the state AFL-CIO, and our union's national leadership. We have made progress but there is much to be done.

In researching literature and periodicals for information as background I have gained a greater insight into the problem of recruitment and retention of nurses throughout the country. It has been stimulating and at the same time discouraging. We are truly at a crisis point in the future of nursing as a profession. There has been great dissention among the leaders of the nursing education field, the nurse executives and the staff nurse working in a local hospital to support themselves and frequently one or more children. I feel that this "in-fighting" has weakened nurses' strength to achieve recognition, salary gains, credibility, and increased benefits as a united front. We have allowed this to happen and a great number of talented, compassionate RNs left nursing for more lucrative careers rather than engage in this exercise in futility.

The image of nursing has suffered, the sense of discouragment and shortage of nurses is at a peak. Potential nursing professionals are choosing more rewarding careers with less shift rotation and weekend work, less risk on a legal and personal health level and for other reasons referred to in this paper.

During my 32 years as a registered nurse, 29 of them in VA service, I have had some of the most heart-warming and heart-stopping, challenging, frustrating and gratifying experiences of my life. On a whole, I have loved being a nurse and would have chosen no other career.

But I am greatly concerned for the future of nursing as a professional- and as a potential care receiver as i grow older. We must do all that we can to recruit and retain young enthusiastic practioners of the art and science of nursing. This paper is an attempt to assist in this effort.

Mary E. McCarte

FACTORS INFLUENCING RECRUITMENT AND RETENTION OF NURSES BY THE VETERANS ADMINISTRATION.

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Image

A leading factor in the crisis of recruiting and retaining nurses within the VA system and the profession as a whole is the image of nursing. "The long held image of the nurse as the maternal, self-sacrificing 'angel-of-mercy' whose reward is in heaven, supercedes a progressive image of an educated health care professional who deserves a quality working life and a reasonably secure living."1 Some nursing leaders (Clair Fagan, Dean of School of Nursing at the University of Pennsylvania) call it "the disposable nurse syndrome - They bring you in, use you for a couple of years, wear you out, and throw you away."

Within the VA system, we have often been "our own worst enemy" in this regard. The community image of nursing at the VAMC continues to be that of a harried, pressured nurse attempting to cope with too many patients and too many tasks. "I've heard how hard you work out there and that's not for me!" is a frequently heard comment in the community when you say that you work for the VA. During times of nurse surplus, particularly of new graduates, recruitment is possible but retention is illusive. New RNs come to the VA for their first hospital experience but often leave before even a year is over, creating a "revolving door" concept on the training wards and increased frustration for all. We must face this fact.

In June, patients and staff of the Minneapolis VA Medical Center moved into a state of the art medical complex which was constructed at a cost of $189 million. It contains 725 hospital beds and a 120 bed Extended Care Unit; has all clinic (out-patient) functions under one roof. It is one of the largest buildings in the upper midwest. During the building process and immediately prior to the move of patients, detailed updates were presented in both Twin City newspapers. On moving day, the intense advance preparation was very apparent and noted by the media with kudos given to the staff.

One particular article by Pulitzer Prize winner John Camp of the St. Paul Pioneer Press Dispatch in the "Focus" section was 5 full pages with many pictures. Patient and staff interviews were conducted and noted. However, one glaring omission was that our Chief Nurse was not approached or interviewed. Nursing Service employs over 800 at this facility, over 580 RNs. Of the total article of 5 pages, 7 paragraphs referred to or quoted RNs. 2 Is it any wonder that nursing staff consider themselves undervalued? We may not be as glamorous but we are essential!

Another problem that occured prior to the move was a radical change in the surgical procedures of patients on particular wards. Nursing Service was told this change would occur with the move, told to train its staff and assure that proper experienced care would be given. This necessitated the breakup of the nursing staff of several wards, approximately 120 staff members, the assignment of different or new headnurses and a great deal of training. This one decision resulted in upheaval of stable working relationships, forcing experienced staff to choose between friends, surgical nursing specialties or off tour rotation and was very traumatic. Our nurse's union requested a meeting with the Chief of Surgery (who made the decision) and the Chief of Staff to discuss the matter and the reasoning behind this as we did not feel we had been given an adequate explanation as co-members of the health care team. On the day of the meeting, several of the RNs attended on their own time but the Chief of Surgery did not appear. We were told that the matter was closed, decided- but that the Chief of Staff would be glad to discuss any concerns that we may have had. Again, is it any wonder that nurses consider themselves undervalued?

Another facet in the image of nurses is the concept that 'a nurse is a nurse' and can float or work in any area. This can be equated with saying that a neurosurgeon is a hematologist is an orthopedic surgeon. Nursing contains specialties, areas of detailed training and accountability- and often RNs are very frustrated by what is considered by management to be their ability to work in any area. The more attuned, informed Chief Nurse's understand these frustrations, often form float pools or have on call RNs who may be assigned to cover emergencies!

'Floating' was one of the major causes of the recent strike in LA County of 3000 RNs. Their concern about indiscriminate floating, being treated 'like robots' was high on the list of griemances, said Sandy Delahoussaye, local spokesperson for Service Employees International Union.[3] Often hospitals are willing to use them (RNs) as all purpose employees who can stand in for anyone- a secretary, a nurse's aide, or a hospital manager after hours.

Stress

Stress is another leading factor in the recruitment and retention of nurses. Stress decreases efficiency, morale and performance.[4] A common factor in stressful situations is the preceived lack of control and the feeling of possible impending catastrophe. Lack of knowledge or skills in a particular area or disease process increases anxiety and can ultimately affect patient care.

Another factor of stress is staff shortages or increased patient/nurse ratio. The present nursing shortage throughout the country is forcing many hospitals to increase the number of patients each nurse is assigned. St. Luke's Medical Center in Milwaukee reports that now they must assign up to 6 patients for every RN instead of the 4 or 5 in the past. The staffing ratios at the VA in Minneapolis are usually 1: 6-8 for days, 1:8-10 on evenings, and 1:10 to 14 for nights on a typical medical or surgical ward. (This of course varies with changes in the census and acuity level of patient.) And from conversations with RNs in other VAs, it appears that our facility has one of the better ratios! In comparison with the other hospitals here in the metro area however, we carry almost twice the number of patients per shift, certainly a factor in retention.

Staff shortages or high nurse/patient ratio frequently leads to the instructions from headnurses and supervisors to "prioritize" care. This often equates to "praying you don't goof" as one nurse put it. The advent of DRGs and the attending criteria for payment of hospital care has made hospitals mini-intensive care units with only very ill patients being admitted.[5] Treatments, diagnostic procedures, complicated nursing care have intensified with the increase of acuity and increase of age. It is not uncommon to have 12 to 20 IVs going at one time on a typical medical ward.

A recent study describes the effects of nursing staff shortages on nurses, physicans and patients. They found that when nurses are "working short" they reported decreased monitoring of patients, omission or delay in delivering certain treatments, poor charting, and an increase in medication errors ,and accidents.

Another article, "Nursing Staffing, Patient Outcome and Cost" details a study of a 482 bed University affiliated hospital in the north east United States. Two general medical units were studied, both with the same budgeted staffing levels and a 40 patient census. From March to June, 1986, patients were classified according to accepted criteria as to acuity level. One unit was consistently short, one at required staffing levels and the number of beds available remained the same. The sample was composed of 199 men and 298 women with the gender level distribution identical for each ward. Over half, 52%, were over the age of 70, the greatest number in the 71 to 80 range.

The short staffed unit, A, had a higher incidence of complications ranging in severity. Group A had 110 patients with complications, group B 81, ranging from infections, heart conditions to gastrointestional disorders. The acuity level of patients on Ward A remained higher, possibly due to the complications. The length of stay on Unit A averaged 9.49 days, Unit B, 8.56 days for a difference of 1.28 days. The cost to the hospital for both units was increased due to the length of stay (DRG factor) but Unit A cost the hospital $37,730 more for a three month period.

The authors stated:" Nursing staffing levels make a difference in patient outcome in areas that can be translated directly into benefits for the hospital. This is especially true on units that have an elderly, chronicall ill population, the type studied. By reducing complications acuity levels and length of stay through adequate care, nurses can potentially save hospitals a great deal of money. It behooves hospital administrators to develope more attractive compensation packages and increase budgets for nursing hiring and retention. When units cannot maintain an adequate level of nursing staff, patients suffer and hospital lose financially. Nursing administrators need to capitalize on this fact, especially in light of the current nursing shortage, if they wish to strengthen the position of nursing within the hospital organization and to maintain adequate staffing levels during this era of cost-containment. Finally, on the basis of the data reported in this study and others, nurses might better realize how valuable nursing is to the economic welfare of healthcare institutions- to say nothing of the welfare of patients."3

Intensive care units have their own special needs and problems. The training received here in Minneapolis is excellent and RNs completing this orientation are premier candidates for 'head-hunting' by other metro hospitals here in the area. The patient/nurse ratio in intensive care units is generally the same, and is closely monitored by accrediting associations.

A prime source of difficulty in recruitment and retention is the number of weekends or off tours worked, and the methods of compensation for this assignment. Number one on the priority list for almost every RN was the number of weekends worked. Every other hospital in the metro area has every other weekend off as criteria for their nurses- here at the VA the usual is every third off. This is a prime factor in keeping nurses at the VA, and cannot be stressed too much. It is especially a factor in retention of younger nurses, as well as those with families. Other VA nurses around the country fare worse than in Minneapolis, some have reported working 4 to 6 weekends without one off.

Days off and annual leave are other areas of great concern. We again have an agreement that days off will not be split unless it is done to facilitate scheduling a weekend. Saturdays and Sundays may not be split, and weekends are scheduled at both ends of annual leave. Annual leave is granted according to an agreement by February of the year and is not changed without the permission of the RN. Some VAMCs RNs have had their annual leave cancelled days before it is scheduled, most demoralizing! We also have agreed that the RN will not work longer than 6 days without a day off. All these agreements have been workable for this nursing service and have greatly increased the staff morale and mood.

Overtime is another area of concern, and mandatory overtime is paramount. This occurs when there is some sort of a staffing crisis and in order to cover patient care, an RN is 'mandated'to continue working. Again we have an agreement regarding this with criteria established for selection,and limitations noted. This is a serious concern in intensive care units, as there is a limited number of RNs trained to give this critcial nursing. One item that particularly irritates staff is if you work an off tour and are scheduled for a 12 hour shift, you get differential for 12 hours. However, if you are mandated to work 4 hours beyond your 8 hour off tour, you do not get the differential as this was not'scheduled' time! And there is a cap on the amount an RN can earn on overtime so that she/he may not receive true 1½ pay! Also if you work parttime, and the overtime that you are mandated to receive is not in the same day (work 1530 to 24, mandated 24 to 04) you receive straight pay and no overtime at all! This is viewed as unjust by all, but our personnel service and union advanced this matter to GAO with no satisfaction.

As long as pay is being referred to- salaries are another area on concern. RN and LPN salaries at this medical center are not competitive with those in the area. Nurses consistently leave for higher salaries and better benefits, and we start the orientation of a new staff member only to have this reoccur in 9 to 12 months frequently. We are always several steps behind in the race to recruit and retain, (and sometimes blocks.) It is rather discouraging for a new RN to find out that one of her high school classmates is earning more as a cashier at a large food store than she is as an RN, making life and death decisions.

Another stress is professional liability and danger of possible litigation. A recent article in a Nursing '88 journal entitled "How to Chart With a Jury in Mind" alerts RNs to this possibility. Often when working short-staffed, the nurse has to choose between charting or caring for the patient...And it is generally by her charting that her supervisors evaluate her performance. Our union created the "Pink slip" to officially notify the supervisor that in her opinion a dangerous situation exists on her area that jeopardizes safe patient care. This original has been adapted throughout the country by both VA nurses and state nursing associations.

Stress of assisting physicans new to the ward, the hospital or medical/surgical subspecialty adds to the charge nurse's dilemma. "A lot of physicans come out of training overwhelmed by the responsibility of caring for patients. They want you as the nurse, the person who has been there all the time, to make it easier. Nurses would correct their orders and clean up the emotional mess they leave hanging with the family." (States Mary Lewis Sheehan, an RN with advanced training in mental health who now participates inprivate psychiatric practice.) This is definitely a factor in a medical center associated with the University, as ours is. We have many levels of students from the medical school as well as interns. (They are referred to by our staff RNs as 'baby Docs'.) Another stress factor when students or interns move to different wards frequently for their training is that staff RNs in the area are frequently called upon for information about routines, lab tests, placement of equipment and so on- truly irritating if the nurse is pressured with many acutely ill patients.

Another stress facing all nurses is their own personal physical health. The spector of 'catching something' from a patient is a very real and terrifying danger for all health care workers. Hepatitis is high on the list of dangers, but the most disasterous possibility is now Aids, Acquired Immune Deficiency. Any needle stick or contamination of unbroked skin or mucous membrane with blood has always been frightening but now the dreadful deadly possibility haunts us. This factor alone is causing many potential nurses to shun the career.

Equitable Compensation in Salary and Benefits.

Although mentioned earlier, salary and compensation need further discussion. The beginning salary for a Junior Grade Nurse, (Associate Degree 2 year or 3 year Diploma) at our facility is $22,582 or $10.85 an hour. An RN with a Bachelor's Degree in nursing begins at $23,834 or $11.45 an hour. An Intermediate Grade RN, step 10, earns $36,232 or $17.41 an hour. and would take approximatley 12 to 15 years to achieve.

The compression factor is most discouraging for the more experienced members of the nursing staff. Salaries are frequently being raised in the first two or three steps of the first two grades in order to recruit new members for the wards. The salaries then begin to compress in the higher steps and grades- it is possible for an RN on staff for 5 years to be earning the same salary as a newly recruited RN with one years experience. This leads to great anger and frustration to the 'on board' nurses. This is one of the most frequent complaints that I hear- "I guess that I should just quit, work someplace else for a while and then re-apply!"

Another factor in the resentment the compression causes is that the experienced RNs are constantly orienting the new nurses, working the weekends and off tours while they are in training, and at the same time earning the same or very comparable salaries. New York University Medical Center boasts of a 'career ladder' but pays a staff RN with 7 years experience only $6,000 more than an RN without experience.

In many institutions there is a lack of any plan for assisting a RN in achieving higher education or rank. The recently enacted Veterans Omnibus Health Care Act of 1988 has some provisions for educational grants, tuition reimbursement and so on for staff in health care. This is commendable but needs to be greatly increased and widely publicized. Active recruiting needs to be done on the college and junior college level so that potential staff members are notified of these benefits and the information needs to get to every financial aid office.

There is also no established criteria for rewarding an RN who has applied and studied for advanced certification in her area. Many areas of nursing now have detailed examinations and plans of course study that lead to this national accreditation, such as CCRN (Critical Care RN, ORRN). These advanced accreditations take a great deal of time and effort (one RN described it as studying for state boards) and cost $125 to $200 to take the exam, with recertification required every 5 years. 'Usually' the supervisor or headnurse recommends a special advancement for this professional initiative, but there is no guarantee. This salary increase of at least 2 steps should automatically be granted as a reward for the nurse's voluntary incentive- one step hardly covers the cost of the effort over the year.

One irritant, regarded as grossly unjust by the professional staff, is the fact that if an employee is in a 'special pay category' (an effort to recruit or retain) that employee is automatically barred from the yearly pay comparability adjustment usually granted. Management and personnel have to apply to Central Office for waivers to allow the special pay employees this added compensation, and frequently the amount granted is less than the other employees receive. This is seen as counterproductive, a 'two steps forward, one back' type restriction. There is always a noticeable lag time in this action also.

Licensed Vocational Nurses or LPNs have some particular problems regarding pay that need also to be addressed. When working off tours their premium pay is limited to the hours of 1800 to 06 so they receive it for only 6 hours of the tour. In the recent Omnibus Veterans Health Care Bill of 1988, only RNs were granted the Saturday pay. This is very frustrating to the dedicated employees within this classification and is a strong deterrent to recruitment, retention and morale. I have worked with LPNs who were excellent bedside caregivers but they transfer to Building Management for better salaries. These inequitable restrictions must be changed.

The Positive Factors to Nursing in the VA

There are some definite advantages to working in this organization. One of the most valued and a major factor in retention is the annual leave granted or accrued yearly. This has been the deciding factor for many new RNs, the single most impressive feature of the benefit package.

The accrual of sick leave time is another important factor for both recruitment and retention. The possibility of advancing sick leave in limited circumstances is a rarely used but effective item.

Many of the local hospitals do not offer full-time employment. This is a plus for the VA. Also some area hospitals will call the staff nurse several hours before they are scheduled to work and tell them not to come in for that shift due to low patient census. For a single pay check family or person, this can be a devastating event.

In my estimation, one of the highlights of VA employment is NO Charge Slips! Every item used for or by a patient is charged to his account in private institutions, and the nurse must assume a role as bookkeeper. This stands in the way of quality patient care at times and is a highly valued omission at the VA.

Establishing float pools within Nursing Service is a positive response to cover prolonged sick leaves, emergency leaves, increases in patient acuity levels. This prevention of floating by another wards' staff is high on the priority list of positives.

There is an elevation in the autonomy of practice allowed to RNs working in the VA setting. Innovative approaches are frequently attempted to facilitate improved patient care. Nurse specialists or Nurse Practioners are allowed great leeway in their practice of expertise areas. Staff nurses at the ward level are encouraged to try different methods or adaptations of treatment, and may receive incentive awards for their effort.

Another plus is the capability of an RN or other employee to transfer within the VA system itself. It is necessary to be licensed in only one state and your accrued benefits travel with you.

But probably the most critical factor to recruitment and especially retention is a responsive management. Personnel need to feel that the directors of the hospital, nursing service and personnel are 'in their corner.' Staff needs to percieve that someone is hearing their frustrations and attempting to alleviate them- or lessen the impact. An open door policy or method of communication is imperative. (Of course I feel that the union is very effective in this transmission of information to all the leaders of these departments!)

The present Director of the VAMC in Minneapolis, Thomas Mullon, and Chief Nurse, Betty Theiss as well as Roger French, the Chief of Personnel have all been very responsive to the frustrations and concerns of staff nurses. (I must also acknowledge Don Schimmel, the Assistant Chief of Personnel, for his extraordinary dedicated work on behalf of the staff.) Despite current budget crunches they have worked within imposed limitations for the strengthening of the position of Nursing Service at this particular hospital. Effort has been made to assure nurses that they are a valued co-member of the health care team.

Suggestions for Enhancing the Image of VA Nursing

There has to be a nationwide attempt to publicize the positives of nursing to the public. The status of the nurse as a career professional with dignity and just compensation must be stressed. Each nurse must be an ambassador and a satisfied employee is the best advertisement an organization can have.

We must actively recruit in junior colleges, technical schools and on college campuses. Financial aid offices must have the information to assist potential candidates for nursing. More scholarships, tuitition aid and grants must be funded- this is an immediate need. We must insist that colleges and universitys have 'career ladder' cohcepts in health education so that a potential degree seeker does not have to start at the bottom.

Each hospital should have a nurse ombudsman to represent nurses in problem solving. Too many just go on to another employer when difficulties arise. (Again, I feel that the union is very active in this role.) It costs from $1200 to $2000 to orient a new nurse to the hospital setting, and from $8,000 to$12,000 to orient, train an ICU RN.

Hospitals should fund refresher courses for RNs returning to nursing. Fairfax CountyHospital in Virginia instituted this type of program: of the five RNs taking the course, 2 were immediately hired and 2 more were investigating employment at that hospital.

Benefits within the present VA structure of employment that need reevaluation are:

- 'True' 1½ time pay for overtime,
- All benefits need to be pro-rated according to the amount of hours the nurse works,
- Child care facilities need to be available on the grounds at reasonable cost,
- Educational opprotunities must be available and publicized to all staff members,
- Mandatory overtime should be abolished. If an RN is mandated, they should receive differential just as though they were scheduled to work the shift, and if parttime should receive overtime pay for continuous work even though it may fall into another 24 hour pay period.
- 'On Call'pay must at least be on a par with the local community rates for on call,
- Experienced RNs should be able to chose their tour- days, evenings or nights,
- Special pay rates should be considered for weekend work such as the 'Baylor Plan' so that RNs will request to work these less preferred tours,
- Alternative work schedules should be investigated with 10 and 12 hour tours available to staff,
- Float pools should be established in every Medical Center,
- Special effort by staff in initiating new programs, becoming certified in specialized fields must be monetarily rewarded.
- Prevent the compression of salaries for experienced staff- when entrance rates are raised, increase all staff salaries the same amount,
- Fund or provide CEU (continuing education credits that are mandatory in many states for relicensing),
- If on a permanent off tour you should receive differential while on annual and sick leave as incentive to stay on that tour,
- Change the Title 38 law that prohibits full-time RNs from outside employment as a nurse (ICU RNs frequently go parttime when on 12 hour tours as they have blocks of days off and can earn higher salaries in the community)
- Investigate ways of'rewarding' or compensating staff for not using sick leave but continue present methods of accruing,
- Guarantee annual leave early in the year according to established criteria, do not split days off or breakup weekends.

- RNs working as 'Charge Nurse' should receive extra compensation for this assignment. Often in the charge role the RN has the same number of patients assigned as other members of the staff.
- All VAs should use the 'bonus' plan allowed by the Veteran's Omnibus Health Care Plan of 1988, and reward employees who stay in the service with the cash bonuses at the end of several years of service, as well as keeping their salaries competitive and avoiding the compression that is now occuring when entrance rates in grades are raised but higher steps within the grade are not.
- Continue to investigate methods of increasing benefits (dental insurance, etc.) so that the VA can remain competitive as a local employer.

These proposals may sound expensive and unreasonable, but the alternative is to continue the 'revolving door' employment that now exists at many Medical Centers with the exiting disgruntled employees telling their friends and neighbors how impossible it is to give quality nursing care. The alternative may be to close wards or at least beds and refer the patients to community hospitals for more expensive care. (On one particular weekend here in the Twin Cities, Every intensive care bed was occupied and patients had to be transported to community hospitals outside the city proper!)

In one study, staff nurses were asked to list their priorities for job satisfaction. They listed in order:

1. Participatory management.
2. Administrative Support.
3. Adequate staffing.
4. Flexible work schedule.
5. Competitive salary and benefits.
6. Recognition. [8]

The staff nurses at our medical center list weekends off very high on the priority list and this is a major factor in many newer RNs decision to work elsewhere.

But the greatest reason for leaving VA employment as an RN is the continuing frustration at not being able to give the quality of care that the nurse feels is necessary for the patient. The constant pressure to 'prioritize', to balance patient needs with staffing availability, to cut corners and do the very minimum, to have new demands constantly made upon your time with no more staff to accomplish the added assignment, to know in an emergency that your other patients may not be monitored as they require...The pressures increase. The nurses graduating at this time have cared for a very limited number of patients during their training. To be suddenly thrust into the stark realitites of nursing in the VA system with at least twice as many patients assigned per shift is very frightening and traumatic, and many leave within a year for less pressure and more job satisfaction. Those RNs remaining are frequently those with years invested in the system who feel that they can't leave, and the stress mounts for them with new orientees appearing on the scene.

All of the evidence points to the fact that the present shortage of nurses is going to increase. It is a real threat to the quality of care in the future of every American, veteran or civilian, publicly or privately hospitalized. We must face this crisis and take bold steps to assure the standard of quality, competent, empathetic nursing care for all, but certainly for this country's veterans, for we are mandated "to care for him who shall have borne the battle..." [9] We must also remember the Veterans Administration motto: "To better serve our country's best" and do all in our power to achieve this goal.

Footnotes:

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5. Quote from Helen Fergesbaum, Assistant Clinical Director of Med. Nursing at Yale-New Haven Hospital, New Haven, Conn.

6. Prescott, P., and K. E. Dennis, J. Creasia and S. Bowen, "Nursing Shortage in Transition", Image, 1985, 18:123-127.

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9. Lincoln, Abraham: Second Inaugral Address, March 4, 1865.

Opening Statemenmt:

Senate Veteran's Affairs Committee

September 9, 1988

Roger Des Prez M.D.
Chief, Medical Service
Veterans Administration Medical Center, Nashville Tenn.

I am Roger Des Prez, President of the Association of Veterans Administration Chiefs of Medicine (AVACOM). I also have been for 25 years Chief of the Medical Service at the Nashville VA Medical Center, and Professor of Medicine at Vanderbilt University. I would like to introduce Dr. Norton Spritz, Chief of the VA Medical Center at the New York VA Medical Center since 1969 and Professor of Medicine at New York University School of Medicine who is here to answer any of your questions concerning AIDS.

I would first like to express the gratitude of the membership of AVACOM for this opportunity. It comes at a crucial time. AVACOM is made up of senior physicians most of whom are professors of medicine and leaders in their medical schools. As a group we have always regarded the VA as the best place to be, the best possible setting for integration of the study, teaching, and practice of medicine. A sense of professional gratitude and pride about the VA has always characterized our organization, its members, and its meetings. However in our last meeting in Washington in the spring of 1988 the sense of the meeting was rather one of concern and anxiety, conern about what we all regard as absolutely critical underfunding, anxiety about whether or not the system could survive unless its resources should be substantially increased or its work load substantially decreased. I will try briefly to trace and illustrate some of these problems.

For the past 8 years funding, expressed in adjusted dollars, has been unchanged. During much of that period increasing work loads and new programs have been accomodated by improvements in efficiency and technology. Probably two years ago but certainly in the present fiscal year this accomodation of increasing work load by increasing efficiency of operation has no longer been possible and resources have had to be redirected from non-recurring budget items to meet operating expenditures. In my own hospital, where I participate in planning, it has been necessary to redirect over $600,000 from non-recurring (equipment, maintenance, and new programs or construction) to recurring (operating) costs. This means deferring procurement and replacement of equipment, and maintenence and construction of buildings in order to buy drugs, supplies, and pay salaries. In addition is has been necessary to severely curtail employment in our hospital during the last half of this fiscal year in order to meet budget requirements. This has resulted in longer waiting time for elective procedures, backlogs in filing, lab work, mail-out prescriptions, coding etc, deterioration of hospital maintence and cleanliness, increased employee stress, errors in record keeping and filing, and inevitably a negative impact on our ability to provide patient care. In Table 1, appended, the amount of money which had to be moved from non-recurring to recurring costs in several hospitals this fiscal year is presented, together with the decrement of personnel over this fiscal year. These data were acquired by telephone from other Chiefs of Medicine and and are incomplete and approximate, but I believe that they reflect the general trend and extent of the problem.

The budgetary short fall in all of our hospitals will be exacerbated by additional requirements which have been placed on us for the coming year without additional resources. These include; (1) universal precautions for AIDS; (2) occurrence screening for accreditation and increase in Quality Assurance activities; (3) a Federal pay raise of 3% to 4% most of which, it is anticipated, will not be totally funded; and (4) special pay rates to recruit scarce technical and professional staff, also not fully funded. In our hospital it is conservatively estimated that these new requirements will cost an additional $600,000 in the next fiscal year.

In order to reach some estimate of deficiencies in equipment throughout the system, a list of the highest priority items needed at 25 medical centers has been compiled (Table 2). It is important to emphasize that only the highest priority items were tabulated. If this figure can be generalized to all hospitals by multiplying it by 7, it would be 87.5 million dollars. Knowledgable colleagues believe that this is actually far too conservative an estimate and that the cost of equiping our hospitals at or close to parity with the private sector would be more than 10 times this.

Perhaps the most critical daily shortage we face in providing patient care is in nursing. Although this is a part of a nation-wide problem, in the VA it is worse. Charts 1 through 7, appended, present data gathered by one of our members which compare several VA hospitals to their paired university hospital and to nearby community hospitals. To summarize, the community hospital group had approximately 180, the university hospitals approximately 140, and the VA hospitals only 80 Registered Nurses per 100 operating beds, operating beds being defined as percent of authorized beds actually occupied (Chart #2). In the special category of intensive care unit nurses, the disparity was equally marked (Chart #4). As a result the VA has to depend more on nursing aides and practical nurses (Chart #5). Although permission has been granted to individual hospitals to pay wages and structure schedules which are competitive with the private sector, again adequate funding has not been supplied in a timely fashion and most hospitals cannot afford these increases within their present budgets.

The same study compiled data to indicate that the VA hospitals surveyed had approximately one-third as many respiratory therapists as the nearby private or university hospitals (Charts #6 and #7). This disparity obviously further compromises clinical care in intensive care units.

Cardiology is a special area of concern for all of us who are responsible for medical services, since many of those we serve are older males with coronary artery disease. Table 3 presents the waiting time for cardiac catheterization and cardiac surgery in 14 randomly surveyed VA hospitals. In the private sector of this country no such delay would be countenanced. All of us personally know of instances in which such delays have resulted in unacceptable outcomes.

Physician salaries in cardiology in the VA lag so substantially behind the community that it has become almost impossible to recruit and retain staff. The attractiveness of the opportunity for research and scholarly endeavors in the VA has been rendered moot by a work load which leaves no time for such activities. Accordingly many stations have a critical lack of cardiologists and this is getting worse at the very time when our patients most need them. VA salaries for non-professionals such as cardiac catheterization technicians lag $5,000 to $10,000 behind those in the private or University sector in many areas of the country. And of course the lack of intensive care nurses has forced many hospitals to close coronary care beds, thus both limiting the total quantity of cardiac care available and often making it necessary to care for certain patients on general medical wards who really should be in coronary care units and in the private sector would be. Many hospitals have to contract for their cardiac surgery in the private sector at prices in excess of what these operations would cost in the VA as established VA programs have little or no resources to expand to accomodate more patients. The whole area of medical and surgical cardiology in the VA is in crisis.

I would like for a moment to address the special problem of AIDS in the VA system. Briefly, under the present Resources Allocation Model (RAM), the reimbursement for the AIDS case load is just a little more than a third of actual cost. Further, as will be discussed below, reimbursement for work units in the VA system lags 24 months. There is now ongoing a vigorous and informed effort on the part of VA Central Office to adjust to the AIDS problem, and it is likely that those hospitals with the largest AIDS patient loads will be protected in the short term. However AIDS is no longer geographically confined, the problems faced by the hospitals on both coasts will soon spread, and, perhaps most importantly, there is no new money in the system to provide for this new and geometrically increasing problem. Accordingly its solution will be at the expense of other areas and other patients if no new resources are provided. Dr. Norton Spritz, whose hospital has been one of those most involved with AIDS in the VA and who had planned to address this committee separately, has prepared a statement which is appended. He will, as mentioned, be glad to respond to any questions concerning AIDS.

Finally I would like to briefly present the view of the field concerning the impact of the Resources Allocation Method (RAM) on our patient care activities. The shift from funding on an essentially historical and to some extent political basis to the present (RAM) system based on measured work load (DRG system) has had several salutory effects. There is no question but that it has considerably increased efficiency throughout the system, and has to some extent redressed prior discrepancies in the level of funding of different hospitals. However, as mentioned at the start of these remarks, during the time the RAM system has been in effect the total funding of the VA medical care system has, in real dollars, been on a straight or slightly decremental line. It was believed, accurately at the outset, that increased work loads could be accomodated by increased efficiency, decreased lengths of stay, and the like. However we believe that this is no longer possible, and for some time the price of further increases in work loads has been compromise of the overall quality of care. Further, this fiscalization of the system, which inevitably produces inter-hospital competition for the fixed amount of overall resources, has introduced a subtle but real bias against those patients with complex illnesses, who are more expensive to take care of, in favor of those with simpler problems and a higher "profit index" in terms of measured work units. The bias in the private sector against the old, those with serious and complicated problems and the long-term ill is thus creeping into the VA system, in which such patients should be the first priority. The tendency for hospitals to become involved to one degree or another in this essentially pernicious competition is ineluctable, since to refuse to do so inevitably compromises the hospital's overall resources. The terms "RAM winner" and "RAM loser" are now commonplace and regarded as indicative of managerial skill, resources are deployed in ways which are fiscally favorable rather than determined according to the needs of patients, and a whole new cadre of management utilization review personnel has appeared whose whole purpose, it appears to us, is playing the RAM game rather than enhancing our traditional role of taking care of the Veterans' health problems.

In summary it is our belief that the VA medical system is in crisis. If we are to provide quality medical care to the service connected veteran and to those veterans whose financial situation make us their only resource, we believe that greatly increased funding for personnel, operating costs, and maintanence of plant and equipment is now mandatory. If this is not possible, then our mission must be redefined. It is our hope that this may become the subject of an in depth analysis on the part of congress and other interested parties such as the Veterans' organizations and medical schools. We believe that the VA medical system, in providing quality medical care to those who have by their service earned it and need it, in its unequalled contribution to medical education, in its productivity in medical research, and by virtue of its very existence as a major alternative system to provide medical care, is an invaluable national resource. We also believe that its continued existence requires prompt rethinking of its funding or else reduction in its workload in a way that preserves its basic structure and mission. Thank you very much.

TABLE 1-PAGE 1

VAMC	NON-RECURRING FUNDS. TRANSFERRED TO RECURRING FUNDS.	FTEE ON-BOARD OCTOBER 1, 1987	TARGETED FTEE OCTOBER 1, 1988
Albany, NY	200,500	1,750.0	1,700.0
Alexandria, LA (1)	300,000	930.0	991.3
Altoona, PA	0	407.6	398.4
American Lake	800,000	820.0	760.0
Ann Arbour	0	1,180.2	1,167.0
Ashville	618,636	1,032.0	991.0
Augusta, GA (2)	0	2,029.9	2,030.6
Baltimore	509,000	937.6	904.7
Bativia	0	435.0	420.7
Bay Pines, FL (3)	714,000	2,036.9	2,017.4
Beckley	312,666	382.4	363.0
Bedford, MA	317,855	1,275.0	1,210.0
Birmingham (4)	727,576	1,328.1	1,264.3
Boston	850,000	1,544.0	1,559.0
Buffalo	1,400,000	1,812.5	1,731.4
Charleston	0	949.0	934.0
Chicago W/S (5)		1,619.5	1,619.2
Cincinnati	1,754,577	1,247.0	1,179.0
Cleveland (6)	1,200,000	2,615.0	2,670.0
Columbia, SC	353,416	1,191.7	1,187.1
Dallas (7)	149,000	2,007.2	2,005.4
Denver	494,000	1,350.0	1,290.0
East Orange (8)	80,000	1,984.8	1,919.6
Gainsville (9)	664,939	1,594.0	1,528.0
Hampton, VA	880,000	1,234.8	1,199.5
Hines (10)	2,200,000	3,216.8	3,091.0
Houston	209,000	2,519.8	2,509.3
Indianapolis	2,600,000	1,444.8	1,413.8
Iowa City	496,000	880.2	858.4
Little Rock (11)	450,000	2,944.4	2,945.4
Long Beach	0	3,042.0	3,042.0
Manchester	855,212	631.7	617.1
Martinez	2,116,000	1,127.9	1,151.6
Memphis (12)	200,012	2,071.1	2,067.0
Miami	0	2,373.0	2,369.3
Milwaukee	0	2,121.0	2,109.0
Nashville	600,000	1,170.0	1,113.0
New Orleans	753,070	1,653.5	1,499.0
New York (Manhattan)	686,000	2,011.0	1,942.7
Oklahoma City	0	1,279.8	1,258.4
Palo Alto	1,433,876	2,615.7	2,590.7
Phoenix	157,498	1,347.2	1,351.6
Pittsburgh	113,325	1,044.4	1,056.4
Providence	503,000	838.2	793.0

TABLE 1-PAGE 2

VAMC	NON-RECURRING FUNDS. TRANSFERRED TO RECURRING FUNDS.	FTEE ON-BOARD OCTOBER 1, 1987	TARGETED FTEE OCTOBER 1, 1988
Richmond	602,000	2,180.0	2,060.0
Salt Lake Cty(13)	400,000	1,262.5	1,168.0
San Antonio (14)		1,928.2	1,962.1
San Diego	1,200,000	1,500.0	1,445.0
San Francisco	990,582	1,315.0	1,137.0
Seattle	709,149	1,638.5	1,563.0
Sepulvada (15)	1,270,000	1,565.0	1,546.0
Tampa	0	2,132.6	2,050.2
Tomah, WI	0	1,007.5	968.1
Topeka	500,000	1,200.5	1,179.2
Tucson (16)	0	1,067.0	1,043.0
Tuscaloosa	0	1,032.9	1,048.8
Walla Walla, WA	0	283.5	285.4
Washington,DC (17)	1,145,667	1,716.9	1,755.4
West Los Angeles	0	3,474.1	3,306.4
West Roxbury -(18) Brockton	1,469,379	2,205.1	2,123.5
White River Jct	693,289	645.1	591.0
Wichita, KS	341,000	579.5	544.3
Wilkes Barre	340,000	1,118.4	1,092.2
Wilmington	627,605	620.0	580.0
GRAND TOTALS	35,987,829	96,499	94,268

Footnotes

(1) Alexandria, LA -
RE: Targeted FTEE 10/1/88 - 95 Additinal FTEE - activation nursing home and clinical improvements

(2) Augusta, GA -
RE: Funds transferred - Expect to transfer funds prior to end of FY 88.
RE: Targeted FTEE 10/1/88 - Increased FTEE due to activation of new building

(3) Bay Pines, FL -
RE: Funds transferred - Expect to transfer additional $500,000 for salary prior to end of FY88. Building activation 1985 - equipment in bad shape

(4) Birmingham, AL -
RE: Funds transferred - Amount $727,576 for Birmingham only.. Huntsville not included in this figure.
RE: FTEE figures FY88 and FY89 include Huntsville Outpatient Clinic

(5) Chicago W/S -
RE: Funds transferred - Figures not available for amount of funds transferred

(6) Cleveland -
RE: FTEE FY88 Targeted 2697.9 (Actual On-Board 2615)
RE: FTEE FY89 Targeted 2692.9 (Expect to have on-board 2670)
Hospital added programs, Domicillary Care 31.9 additional slots/ HCMI 2.1 positions

(7) Dallas -
RE: Funds transferred - Earmarked additional $300,000 to be transferred unless additional funding is provided by VA Central Office

(8) East Orange, NJ -
RE: Funds transferred - $80,000 funds transferred would be higher but major air conditioning project is taking place
RE: FTEE (Actual on-board 9/30/87 1959.8) due to partial hiring freeze till end of FY87..(Actual On-board 10/30/87 1984.8)

(9) Gainsville -
RE: Targeted FTEE 10/01/88 - Anticipated On-Board 1,563

(10) Hines -
RE: FTEE Targeted 10/01/88 - Anticipated On-Board 3,147 - Budgeted 3,091.1 FTEE

(11)Little Rock -
RE: FTEE Targeted 10/01/88 - Additional FTEE due to starting Domicillary Care Program

(12)Memphis -
RE: Funds transferred - No funds transferred to-date but has set aside $212,000 equipment funds in the event it is needed...as a result some items are not being purchased for patient care.
RE: FTEE On-Board 10/01/87 - 2,042 (presently 2,071.1 on-board)

(13)Salt Lake City -
RE: Funds transferrred 50% NRN - 50% Activation Funds

(14)San Antonio -
RE: Funds transferred - Amount of funds transferred not available
RE: FTEE 10/01/88 - 115 additional FTEE for 120 bed nursing home

(15)Sepulvada -
RE: Funds transferred FY86 transferred $447,042 - FY87 transferred $1,016,060 - FY88 (to-date) transferred $1,270,000
RE: FTEE On-Board - FY86 1,753 on-board - FY87 1,691 - FY88 1,565
During these three (3) years hospital has had 1% increase inpatients and 12% increase in outpatient care

(16)Tucson -
RE: Funds transferred - No funds transferred current Fiscal Year FY87 transferred $200,000

(17)Washington, DC -
RE: FTEE Targeted 10/01/88 - FTEE figure includes decrease of 6.1 physician and increase of 44.6 non-physician slots

(18)West Roxbury - Brockton -
RE: Funds transferrred - In addition to listed amount $500,000 received from Region

8/4/88

TABLE 2

EQUIPMENT REQUESTED BY FIELD STATIONS

VAOPC BOSTON		
Survey Spirometer/Tape Backup	$13,761	
	Total	$ 13,761
VAMC CHICAGO, (LS)		
Digital Storage Oscilloscope	734,163	
Ultrasound Scanning System	18,400	
Noninvasive Temporary Pacemaker	20,640	
Fluoroscopy Unit (C-Arm MICU)	195,000	
Fluoroscopic System With DXD-350-11 Generator	169,000	
Cine Loop System with Accessories	18,440	
Zeis Image Analysis System	20,284	
Electro Static Sleep Study System	53,705	
	Total	$1,229,632
VAMC CHICAGO, (WS)		
Cardiac Cath Recording System	316,000	
Upgrading Monitoring System, Respiratory ICU	104,000	
Upgrading Monitoring System, Medical ICU	26,000	
Upgrading Monitoring System, Cardiac Care Unit	48,000	
Mobile Image Intensifier, MICU	88,605	
	Total	$ 582,605
VAMC CINCINNATI		
Recording System, Cardiac Cath Lab	149,623	
	Total	$ 149,623
VAMC COLUMBIA		
Philips Tape Recorder (Angioplasty Procedures)	65,770	
Pulmonary Function System	45,000	
Mingograph Electrophysiology System	76,736	
Matrix Cinestore Video Processing System	179,404	
Body Plethysmograph	65,000	
Laser Coagulator	76,000	
Digital Cardiac Imaging System	584,734	
Phased Array Imaging System	171,000	
MICU Monitoring Equipment	200,000	
	Total	$1,463,644

TABLE 2

EQUIPMENT REQUESTED BY FIELD STATIONS (Continued)

VAMC DENVER		
Automated Electrocardiographic Interpretative System For District 22	$448,000	
	Total	$448,000
VAMC EAST ORANGE		
Coag-A-Mate X2 Data-Mate System (Hemostasis Analyzer)	$34,000	
FACSCAN	80,000	
Endoscopic Computerized Image Mgmt. System (stomach,etc)	95,565	
Computerized Holter Analysis System	63,000	
Laser Compatible Bronchoscope	6,000	
Endoscopic Computerized Image Mgmt. System (large bowel)	62,500	
Cardiopulmonary Exercise Physiology Testing System	32,000	
Bronchoscopy Video Information System	16,250	
Digital Image Process/Video Quantification System	40,350	
Mass Spectrometer	170,200	
Fast Ion Bombardment System for Mass Spectrometer	28,000	
Chromatographic Workstation	61,600	
Ultracentrifuge	63,500	
Crystal Scintillation Gamma Counter	26,200	
Exercise Threadmill	23,745	
GE Mobile Scintillation Camera	203,655	
IBM Computer System	12,500	
Immunofluorescent Light Microscopy	29,200	
Haemonetics Blood Processing System	27,500	
Spectrophotometer	26,000	
Centrifuge	38,500	
Microscope	15,000	
IBM Computer	10,000	
	Total	$1,165,265

TABLE 2

EQUIPMENT REQUESTED BY FIELD STATIONS (Continued)

VAMC FAYETTEVILLE		
Laser Holter Analysis System/5 Holter Monitors	$ 53,500	
	Total	$ 53,500
VAMC JACKSON, MS		
Ultrasound Imaging System	$ 167,157	
Transducer	8,875	
	Total	$ 176,032
VAMC KANSAS CITY		
Echocardiography Machine	170,000	
	Total	$ 170,000
VAOPC LOS ANGELES		
Ultrasound Mode/Doppler	180,000	
Treadmill and Modem	27,000	
	Total	$ 207,000
VAMC LOUISVILLE		
Biplane/Digital Cardiac Cath equip.	1,600,000	
	Total	$1,600,000
VAMC LYONS		
Radiometer Acid Base Laboratory	23,920	
Echocardiograph with Color Doppler	135,000	
Olympus High Intensity Light Microscope	5,723	
	Total	$ 164,643
VAMC MIAMI		
Flowcytometer Upgrade	34,180	
Flowcytometer and cell sorter	110,000	
Microscope	15,000	
Microscope/camera/atts.	9,938	
Blood Gas Analyzer	23,660	
Radiometer Hemoximeter	13,559	
Freeze Frame Unit	5,500	
Laparoscopic Video Information System	30,480	
Artificial Dialyzer Reuse Equipment	55,100	
Caligiscope Catheter	2,000	
Launch Adapter/Fiber Filters	3,160	
Fiberscope	8,000	

TABLE 2

EQUIPMENT REQUESTED BY FIELD STATIONS (Continued)

VAMC MIAMI (continued) Miami total from page 3	$310,577	
Intra-arterial infusion pumps (2)	$ 4,000	
Portable Infusion Pumps (6)	8,000	
Multipurpose centrifuge	2,500	
LAK cell and blood cell processor	30,000	
Cardiac Cineangiography System	850,000	
Hemoximeter	110,000	
Video Camera	9,500	
Resolution Monitor	900	
Video Printer	2,995	
Tape Recorder	1,985	
Bronchofiberscope with accessories	7,663	
High Intensity Light	5,703	
Exercise Treadmill	21,000	
	Total	$ 1,364,823
VAMC MANCHESTER		
Metabolic Cart	$ 49,500	
	Total	$ 49,500
VAMC MILWAUKEE		
Automated Electrocardiographic Interpretative System for District 16	$300,189	
	Total	$ 300,189
VAMC MOUNTAIN HOME		
Automated Electrocardiographic Interpretative System for District 8	$394,821	
	Total	$ 394,821
VAMC SALEM		
Cardiologic Analysis System	$ 29,160	
	Total	$ 29,160
VAMC PROVIDENCE		
Dual Beam Densitometer	$ 57,000	
	Total	$ 57,000

TABLE 2

EQUIPMENT REQUESTED BY FIELD STATIONS (Continued)

VAMC SAN FRANCISCO

Physiological Bedside Monitor/Central Monitor	$ 43,770	
	Total	$ 43,770

VAMC SAN JUAN

Echocardiography Ultrasound System	$189,720	
" Mgmt. and Storage System	71,892	
Exercise Threadmill	27,315	
Sleep Monitor System	98,930	
	Total	$ 387,857

VAMC SEATTLE

Lung Analyzer	$ 44,500	
Cardiac Scan Converter with Remote Control	42,800	
Synthesizer	50,500	
	Total	$ 137,800

VAMC SEPULVEDA

Cardiac Cath Laboratory	$718,244	
Intra-Aortic Balloon Pump	30,000	
Endoscope Videoimage System	25,906	
Automated Coagulation Analyzer	26,000	
Special Hematology Laboratory	6,325	
Argon Laser	30,000	
FACS Scan	80,000	
Volume Ventilator	21,700	
Aloko Color Flow Doppler System	125,000	
35-MM Vangard Projector	21,500	
	Total	$1,084,675

TABLE 2

EQUIPMENT REQUESTED BY FIELD STATIONS (Continued)

VAMC TAMPA

Video Unit Techni-Lab	$ 14,609	
Bronchofiberscope (3) with teaching peripherals	51,531	
Body Plethysmograph	38,750	
Multi-Channel Oscillographic Recorder/with acces.	63,250	
Mass Spectrometer, Quadripole Type	58,000	
Multiscan Plus Automatic Reader	98,500	
Endoscopic Video System	59,327	
Digital Subtraction Angiography	580,000	
Holter Monitor	55,000	
Ultrarac Fraction Collector	4,033	
IBVM Computer/Proprinter/Color Monitor	4,941	
Liquid Chromatographic Equipment	19,000	
Chemistry Analyzer	31,500	
Computer/Lazer Printer	7,553	
Surgical Lazer System with Microscope	33,300	
	Total	$1,119,294
	Grand Total .	$12,392,594

Chart 1

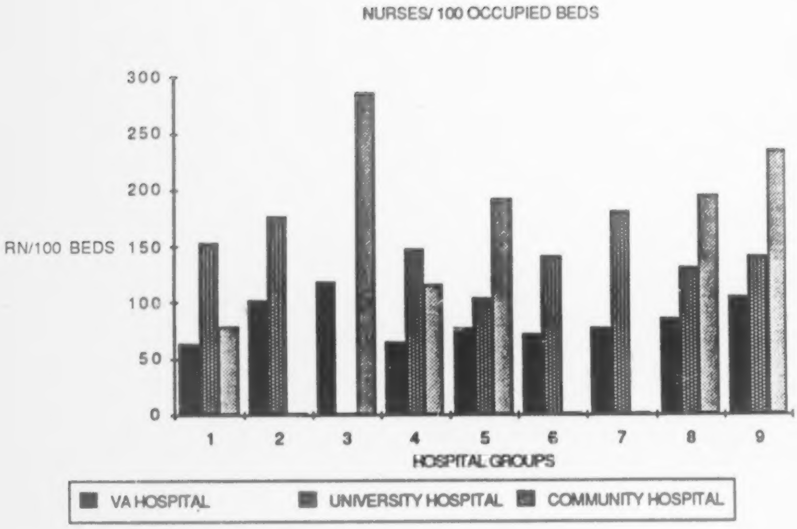
NURSES/ 100 OCCUPIED BEDS
RN/100 BEDS
300
250
200
150
100
50
0
1
2
3
4
5
6
7
8
9
HOSPITAL GROUPS
VA HOSPITAL
UNIVERSITY HOSPITAL
COMMUNITY HOSPITAL

Chart 2

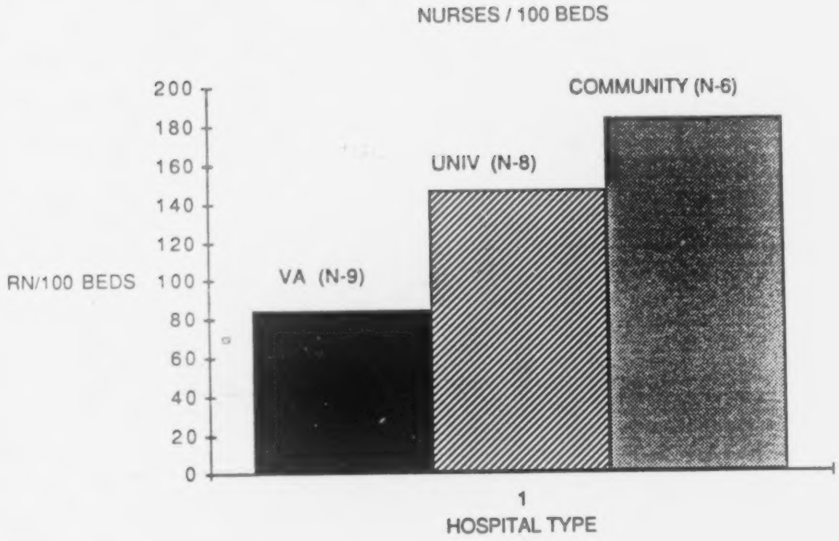
NURSES / 100 BEDS
RN/100 BEDS
200
180
160
140
120
100
80
60
40
20
0
VA (N-9)
UNIV (N-8)
COMMUNITY (N-6)
1
HOSPITAL TYPE

Chart 3

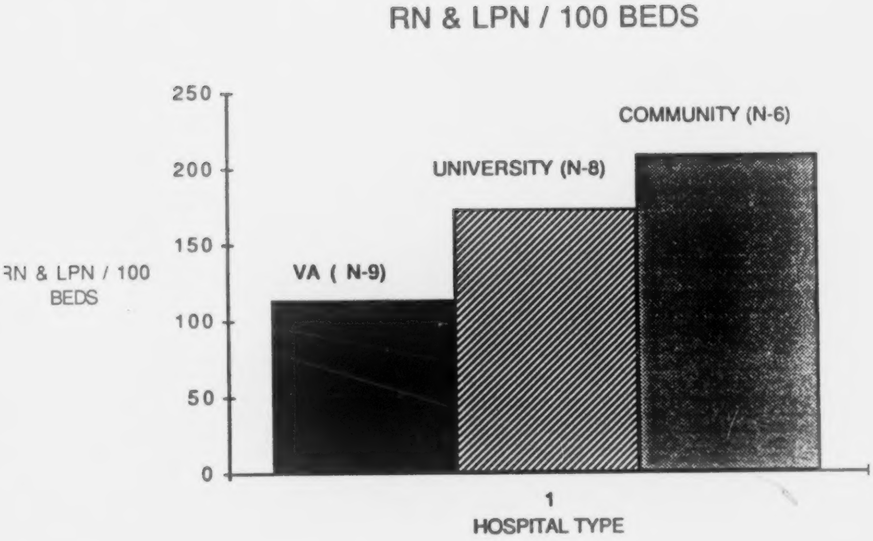
RN & LPN / 100 BEDS
250
200
150
100
50
0
RN & LPN / 100 BEDS
VA (N-9)
UNIVERSITY (N-8)
COMMUNITY (N-6)
1
HOSPITAL TYPE

Chart 4

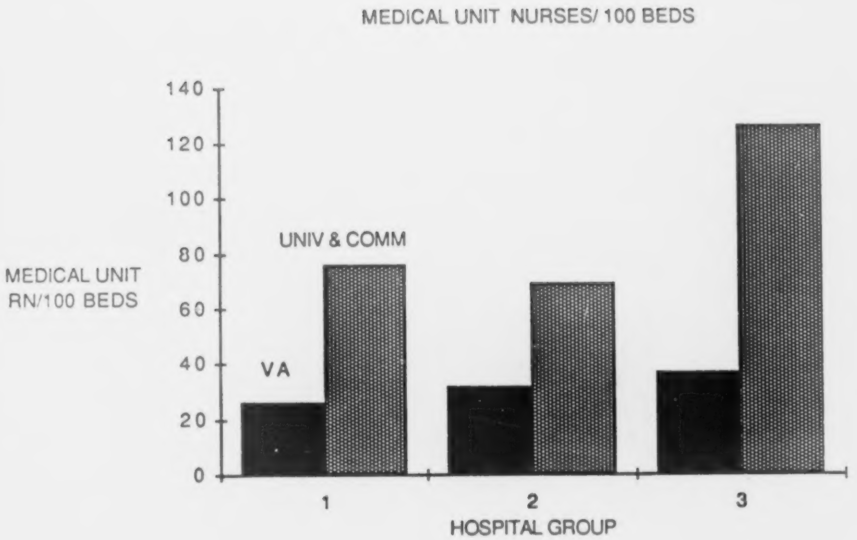
MEDICAL UNIT NURSES/ 100 BEDS
MEDICAL UNIT RN/100 BEDS
140
120
100
80
60
40
20
0
UNIV & COMM
VA
1
2
3
HOSPITAL GROUP

Chart 5

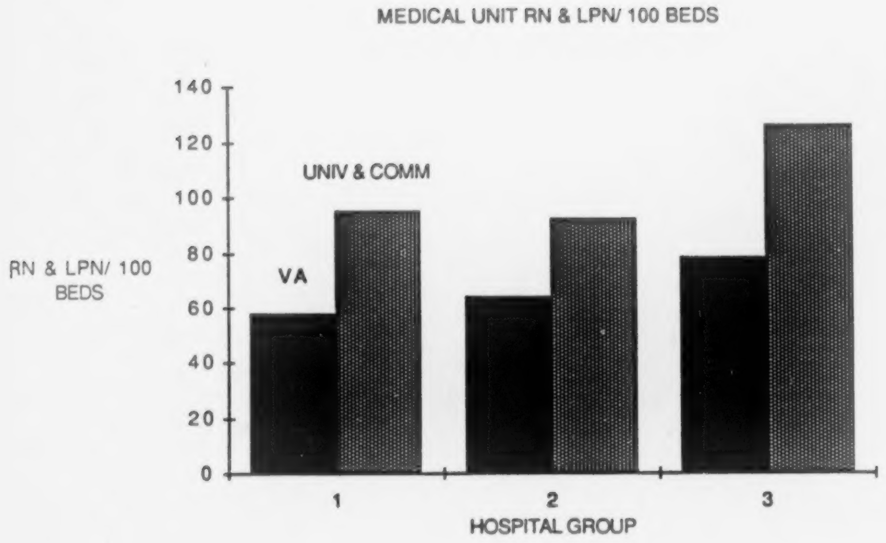
MEDICAL UNIT RN & LPN/ 100 BEDS
RN & LPN/ 100 BEDS
140
120
100
80
60
40
20
0
UNIV & COMM
VA
1
2
3
HOSPITAL GROUP

Chart 6

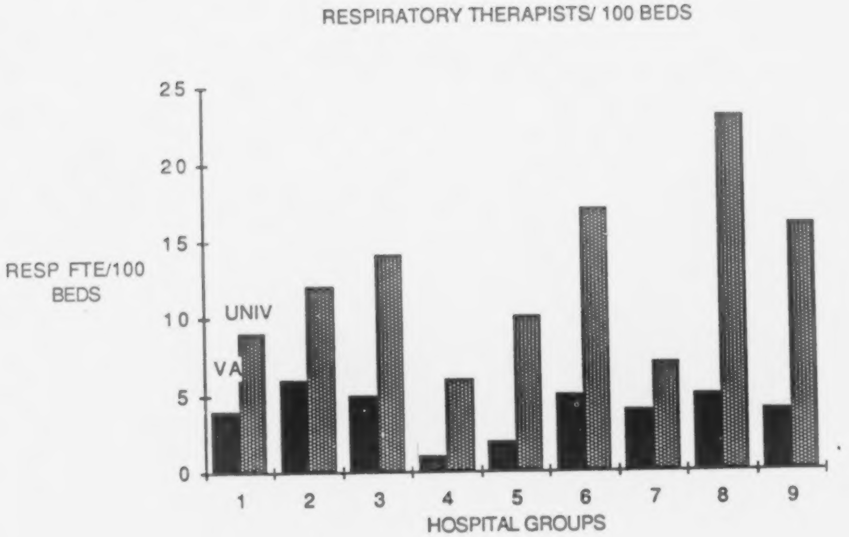
RESPIRATORY THERAPISTS/ 100 BEDS
RESP FTE/100 BEDS
25
20
15
10
5
0
UNIV
VA
1
2
3
4
5
6
7
8
9
HOSPITAL GROUPS

Chart 7

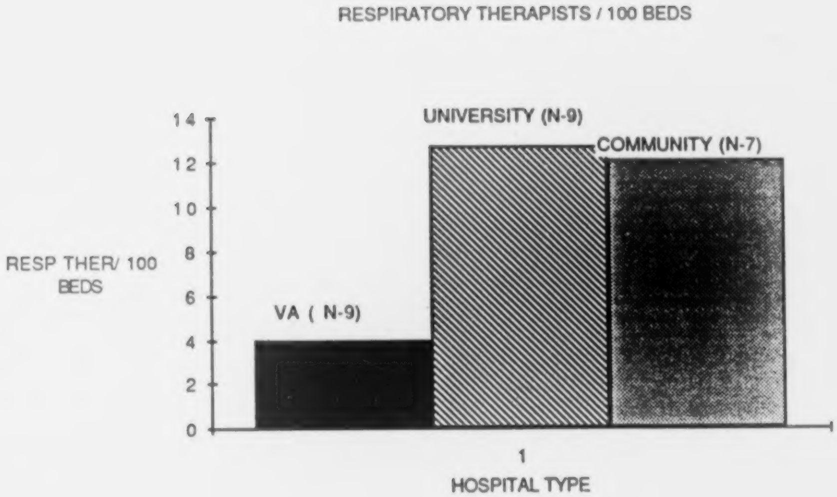
RESPIRATORY THERAPISTS / 100 BEDS
14
12
10
8
6
4
2
0
RESP THER/ 100 BEDS
UNIVERSITY (N-9)
COMMUNITY (N-7)
VA (N-9)
1
HOSPITAL TYPE

TABLE 3

CARDIOLOGY SURVEY

VAMC Location	Waiting Time - Cardiac Cath	Waiting Time - Cardiac Surgery
Miami, FL	1 wk	4 wks
Tampa, FL	5 wks	4 wks
Gainesville, FL	4 mos *	4 mos
Wash. DC	< 1 wk	3 mos[1]
Columbia, MO	< 1 wk	1 wk
Palo Alto, CA	2 wks	2 wks
St. Louis, MO	< 1 wk	1 wk
E. Orange, NJ	2 wks	6 wks
Pittsburgh, PA	2 wks	2 wks
Richmond, VA	4-6 wks	3-6 mos
Wood, Milwaukee, WI	1-2 wks	1-2 wks
Birmingham, AL	4 wks	6-8 wks
San Francisco, CA	No delays	Variable
Nashville, TN	1 wk	3 wks

* Suspect figure for cardiac cath. Seems too long.

[1] This VAMC does not have a cardiac surgical program and must refer patients for surgery. Figure seems too short.

Statement of
A. Wendell Musser, M.D.
President-Elect
National Association of Veterans'
Administration Chiefs of Staff

August 26, 1988

THE MONETARY SHORTFALL OF THE VETERANS ADMINISTRATION FY-89 BUDGET

Prior to his appearance before the Appropriation Committee for the 1948 Budget, General Omar Bradley sent a letter of May 2, 1947 to all Assistant Administrators and Deputy Administrators. It stated: "Next week I shall go before Congress to show why we shall need seven billion dollars for the VA in 1948. However justified our requirements may be, those vast expenditures offer a challenge to reduction in government spending. Even the accepted necessity for our veterans programs cannot save the VA from becoming a target in this effort to reduce the budgets. The VA has sought reductions wherever reductions might be made without impairing our operations but if further reductions in the name of economy threaten to cripple our program and dull its objectives, I feel it is my duty to point out the danger. Where reductions and expenditures for hospital treatment might threaten the standards of medical care, I shall oppose such reductions and defend the budget we shall need." General Bradley, where are you now that we need you?

I fear that we now again address a similiar situation and that the national deficit, and of necessity the changes in attitude toward programs such as the Veterans Administration, are forcing us to tighten our budget belt beyond all reasonable expectations. The Entitlement and Statuatory necessities follow from law to law and regulation to regulation, yet the budgets and expendable resources stay static. Several of our hospitals have experienced budget problems during FY/88 and it is our belief that these budget shortfalls for 1988 for the most part will roll over into the FY/89 budget. It is estimated that this figure will be probably greater than 500 million dollars. The total 1988 budget shortfall for Region 3 is estimated at 88 million dollars, 9 million dollars of which is a spend-down on inventory of drugs and supplies.

Let us consider one hospital, Atlanta, Georgia, as an individual example. In FY/88 this hospital in treating AIDS patients is spending a total of $300,000 for additional cost of drugs and medical supplies utilized in that treatment for which the hospital was truly never budgeted. The projected FY/89 AIDS impact is estimated to be $500,000. The special pay rates for 1988, approved and implemented in order to keep the care programs functional, amounted to $169,000. Some special pay rates were not implemented because they were not funded by Central Office even though they were approved.

Historically,experiences during 1988 indicated an inflation factor in the recurring all-other accounts of approximately 5%, but the FY/88 target allowance contained an increase of 1.5% for this account. The total shortage for FY/88 was $757,000 in all other cost. Based on projections in health care literature the deficit projection for FY/89 is $1,480,000. The recurring two year fiscal year total deficit in the all-other accounts is $2,237,000. The projected two year within grade payroll cost for FY/88 and FY/89 is in excess of 1.2 million dollars. No recurring funding has been provided in the FY/88 and FY/89 target allowance for this item. To survive FY/88, because of the funding problems identified above, a net total of $581,334 was converted from non-recurring equipment and project accounts to all-other. It is a difficult task to face that as the building deteriorates and high technology equipment is not purchased, it is tremendously difficult to offer the quantity and quality of care that our veterans deserve. Unfunded much needed replacement equipment amounts to approximately one million dollars. During the fourth quarter the control points throughout the hospital were reduced 14% and about 1.5 million dollars worth of inventory reductions were allowed.

Several of us have had the opportunity to study the FY/89 budget which by conservative estimates in order to maintain current services and respond to the provisions of PL-100-322 is short by 819 million dollars. A major recommendation made in association with workload reduction represents the initial step in moving this system toward access parity by adjusting workloads and funding in accordance with entitlement and eligibility. Our only recourse was to cut back services and to ration care. We have done that but we have done that with care reviewing every case carefully to insure that the delay did not result in any significant change in the medical condition of the patient. The ethical and moral considerations were an increasing burden to the medical staff of that institution. And to be sure in a way the morale has deteriorated because of it. Some of the staff wonder whether we have broken faith with the group of patients to whom we have dedicated our careers.

A sound and well designed long range strategy is essential to the VA as the department anticipates fiscal shortfalls in the future years. The strategy must include dramatic measures that address service demands and reduce funding levels in outlaying years.

It is my understanding that the present Chief Medical Director and the Administrator have under consideration several policy changes and action plans which will allow the Department of Medicine and Surgery to adjust its workload and program developments in keeping with the proposed budget. Obviously this cannot result in anything but down-sizing of the organization and a reduction of services, hopefully, at the same quality level. It is my fond hope that we are able to keep pace with the changing technology and physical structures necessary to deliver modern care.

We are told that factors like organizational policy and climate can be sources of influence on the behavior of leaders. An organizational climate which provides a general feeling of well being and success may influence leaders to be rational, effective and productive. The successful manager must be a good diagnostician and have a value of spirit of inquiry. The successful manager must have the personal flexibility and managerial flexibility and range of skills necessary to vary his own behavior. We value the guidance of the Congress, we make a plea for individual managerial flexibility to get the most out of these precious health care dollars, to care for the maximum number of veterans at the highest quality level achievable. Reduce the floors, ceilings and fences to allow us maximum flexibilities in these times of budget constraints.

These are not the best of economic times for these United States no matter what the political rhetoric of the moment states. The enormous Federal deficit, the trade deficit, the hysterical and undulating stock market, the cry for high technology in science and medicine, and the expectations of society in care and well-being torment us. Where are our priorities? Where are the health care dollars? What procedures do we use then to ration the care? How does the VA health care dollar needs fit into the national budget picture? Where is our future in the development of the health care system for the nation? We will apply with care to the needs of our veterans those dollars assigned, but we cannot cope with ever increasing needs placed by entitlement, the increasing age of the veteran, and the demands of modern medical science, if we are continually facing decreasing dollars. We can define the base of population and the system. Do you want us to define the budget?

The present FY/89 budget will not do the job. It is several hundred million short of the mark. It is probably 1.46 billion dollars short of the mark to truly respond to the health care needs of the veterans who are presently fully eligible under the statues.

Thank you for allowing me to make these brief comments.

A. WENDELL MUSSER, M.D., President-Elect
National Association of Veterans' Administration Chiefs of Staff

NOVA NURSES ORGANIZATION OF THE VETERANS ADMINISTRATION
6728 Old McLean Village Drive
McLean, Virginia 22101
Phone (703) 556-9222

Statement of Claudette Morrissey, RNC
President, Nurses Organization of the Veterans Administration
(NOVA)

Before the U.S. Senate Committee on Veterans Affairs

September 9, 1988

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Mr. Chairman and Members of the Committee, I am Claudette Morrissey, a Registered Nurse employed full-time as a Staff Nurse at the Veterans Administration Medical Center, Brooklyn, New York. I am here today as the President of the Nurses Organization of the Veterans Administration (NOVA) and I thank the Committee for the opportunity to appear before you. NOVA is a professional association of registered nurses employed by the Veterans Administration, the largest single employer of registered nurses in the United States. While I speak as the representative of NOVA it is my goal to reconfirm the need of Veteran patients for the nursing care provided by over 33,000 RNs in the 172 VA Hospitals and 200 outpatient clinics. This nursing care can be provided only when the VA is able to recruit and retain adequate numbers of Registered Nurses and other health care personnel.

NOVA thanks you Mr. Chairman for holding this hearing on the adequacy of resources to provide for quality patient care on a timely basis.

The question you have asked NOVA to address today is a tough one. The answer touches the heart and conscience of VA nurses throughout the country as each nurse strives daily to provide quality care to the veteran patients who seek and deserve that care.

NOVA speaks today as the voice of nurses who are working in VA hospitals and clinics. The voices you are not hearing today are those of the nurses who have left the VA to work elsewhere, or those of nurses who have never come to work at the VA. The difficulty providing appropriate care is at the center of the challenge to recruit and retain qualified nurses at VA medical centers.

The issues of recruitment and retention are closely intertwined. For it is often for the very same reasons that nurses leave the VA, that the VA is not competitive in recruiting nurses.

In preparation for our testimony today NOVA polled nurses at VA medical centers across the country. When NOVA asked "are there sufficient resources to recruit and retain qualified nurses?" the answer we received from 83% of those who responded was a resounding NO!!

Recruitment

The nursing shortage that NOVA and other organizations have discussed before this committee in the past has moved beyond the urban centers on each coast and is evident now throughout the nation. Many VA nurses report that recruitment of nursing staff is severely hampered because VA hospitals are not competitive with community hospitals in salaries for the entry level nurse or for the highly qualified experienced nurse. They confirm that the VA is also not competitive with local hospitals in fringe benefits, tuition reimbursement, staffing levels, weekends off and shift rotation. VA's inform us they have little or no money available to advertise and attract applicants. For example, some VA hospitals have $500 per quarter for advertising or here in Washington, D.C. the VA hospital has a budget of $15,000 to attract applicants while NIH has a budget of $350,000 to recruit in the same marketplace.

The problems are not identical in every hospital. Some report they have not had a new graduate apply for a position in over two years and others report they can recruit only new graduates who work less than one year and then move on. Many hospitals can find nurses available but due to a shortage of funds there is a hiring freeze and some hospitals report they have resources but can't find nurses. It is not uncommon to take 90 to 120 days to fill vacant positions. The workload for the nurses who remain increases with each unfilled vacancy. This heavy workload affects recruitment because nurses frequently inquire about the nurse to patient ratio when they apply for work and decline employment when they hear the answer.

NOVA has stated in the past that overworked nurses are poor recruiters for the VA system. Retention of nurses already working needs to be our first concern. A cadre of satisfied, enthusiastic competent and caring nurses will be our best recruiters for the future.

Retention

The issues involved in retention of nurses is very closely related to those of recruitment. NOVA is alarmed to hear from nurses with 14 and 15 years of VA experience who are leaving to work elsewhere. They are lured to the private sector by better salaries, fringe benefits and working conditions. NOVA has heard a common theme, there are not sufficient numbers of VA nurses to fulfill the VA mission of quality care. The ability to provide patient care is severely compromised when there are not enough nurses. Nurses know this in our minds and hearts and don't expect others to believe our instincts but we do expect them to believe our data. In VA hospitals we can document this daily by using a patient classification system. This system quantifies the minutes or hours of care patients with certain needs require. The number hours of staff time available should be equal to the total number of hours of care needed by the patients. Nurses tell us the numbers just do not add up.

It is common that the number of hours of patient care far exceeds the number of staff hours available to provide the care. When this happens patients do not get the care they need. As one head nurse on a surgical unit reported, "When I don't have enough nurses my post-operative patients run fevers because we don't have the staff to get them coughing, deep breathing and sitting up."

To nurses an excessive workload means working so fast that you fear you will make a serious life-threatening mistake or that you will not be available to observe when a patient's condition changes for the worse. Many nurses entered Nursing for humanitarian and altruistic reasons and are not afraid of hard work. What we do fear is that harm will come to a patient because we are unable to give them the nursing care they need.

Nurses throughout the country tell NOVA that the Nursing FTEE has been cut at their hospitals. Often when nursing positions are vacant because of recruitment difficulties, and the hospital budget requires that positions be cut, the empty nursing slots are sacrificed and the ceiling is reduced or frozen at a low number. In this case the vacancy rate looks low and the budget gets balanced.

NOVA's poll confirms the VA survey of field facilities which reported budget reductions were cited for more than half the loss of registered nurses.

Supplies, Medications and Equipment

When NOVA asked VA nurses if there were "difficulties in securing adequate supplies for patient care?" the answer we received from 82% of those who replied was "yes" there are difficulties.

A summary of their most common responses includes shortages in supplies needed for patient care such as, Kleenex tissues, 2x2 and 4x4 sterile gauze pads, urinals, adult diapers, 5cc syringes, foley catheters, IV needles, bedside urine bags, Swan Ganz catheters, colostomy bags, rectal thermometers, water pitchers, mouthwash, toothpaste and a basic hospital staple--SOAP. Nurses in one hospital brought in souvenir hotel soaps for the patients and in another bought and cut large bars of soap in small pieces for patients to use. A national shortage of latex gloves this past year was not unique to VA hospitals but it was an added stress as VA nurses attempted to institute universal infection control precautions.

IV solutions and common medications are also often "out of stock." The tight budget is frequently blamed when drugs are not available. "Liquid haldol is too expensive" we are told "give it IM" (Intra Muscularly) if the patient won't swallow the pill form. "Out of Stock" items may seem like a simple inventory problem but there is an affect on patients, nurses and physicians. For example, when a particular IV solution is not available nurses need to call or find the physician to re-write the doctors-orders for all the patients for whom that solution was ordered. This process absorbs the time of the physician and the nurse and deprives the veteran patient of their attention as well as the first choice in IV solution or medication.

In the name of budget constraints nurses report poor quality supplies are often substituted for those requested or recommended by nursing and medical staff. Nurses report this is particularly frustrating when this happens after the completion of a product comparison and evaluation period of 5 or 6 months, and nursing recommendations are ignored in favor of cost savings.

Nurses from coast to coast reported that the purchase of equipment has been severely curtailed. Many report that no new or replacement equipment has been bought in over a year and that equipment dollars have been used to pay salaries. When equipment such as electric beds, infusion pumps, defibrillators, hydraulic lifts, wheel chairs, wheel chair cushions, and geriatric chairs are not available the quality of patient care suffers.

Nurses are often very inventive in their efforts to minimize patient suffering. At one VA hospital in the south nurses were frustrated by the refusal of prosthetics to supply wheel chair cushions for patients on the long term care unit. The nurses obtained a $25 donation, went to the local upholstry store and purchased a large foam mattress and with an electric knife borrowed from the mother of one of the nurses cut the foam to make wheel chair cushions for her patients.

When nurses in one hospital experience some of the shortages outlined above they are often convinced it is unique to their facility and caused by their: hospital director, chief nurse, chief of MAS, chief of supply, chief of personnel or chief of prosthetics. When NOVA hears similar reports throughout the country it seems clearer that departments everywhere are shifting and juggling and trying to survive in a system that is inadequately funded for the legislated mission.

Support Staff

Nursing is not the only area where there have been staff cuts or there are shortages. When there are shortages in other departments nurses are required to fill in the gaps as respiratory therapists, blood drawers, ward secretaries and housekeepers. Systems intended to increase efficiency and accuracy such as unit-dose medication are compromised when pharmacy is short staffed and double pours the unit dose cart. The burden to adjust falls on the shoulders of nurses. When nurses are used as the all-purpose disposable employee, patients are deprived of nursing care and nurses get used up.

It is difficult to know for certain why nurses decide to leave VA employment after many years of service. We often speculate that it is the cumulative effect of working short staffed, without the needed supplies and equipment and without a cost of living adjustment that adds up and any one of these events can be the straw that breaks the camel's back.

As we stated earlier NOVA is speaking today for the nurses who continue to stay and care for veteran patients in spite of all the difficulties described above. We are loyal and dedicated employees who pull together in difficult times, who like taking pride in what we do and dislike seeing the VA attacked and critized from without. We are resentful when non-VA nursing colleagues indicate they think the VA is a second class place to work or assume that if you can't work elsewhere you can always work at the VA. We have glimpses from time to time of how great the VA health care system can be and take pride in the system's accomplishments. We have a worthy mission and need the resources to fulfill that mission.

VA nurses in their responses to studies over the past 20 years, have pointed the way to solutions to the chronic recruitment and retention problems. Blue ribbon panels and nursing researchers have pointed the way--what is needed now is action.

A summary of the five most important steps needed include:

I. **Work schedules should require minimal rotation and more weekends off.**

To accomplish this staffing levels in general need to be increased. Hospitals should hire to shift and pay higher evening and night differentials. We are hopeful the Saturday Premium Pay that began this summer will also have positive impact.

II. **Staffing should be appropriate to the workload.**

To accomplish this, staffing levels need to be increased so that staffing at the bedside can meet the staffing guidelines based on patient classification by acuity. Nurse managers should be able to control patient admissions and close beds when there is insufficient staff to care for the patients.

III. **Salaries should be comparable to the private sector.**

The basic salary schedule for all VA registered nurses needs to be adjusted upward.

Presently 118 facilities are on special salary rates. Twelve of those are at the maximum for Junior grade. This maximum at step 19 is $5,000 less than the community rate for similar nurses. Title 38, Section 4107 (g) provides that the Administrator may set up special salary rates for personnel with specialized skills so that the maximum rates for grades may be increased. This waiver is urgently needed for registered nurses have specialized skills that are urgently needed. NOVA is hopeful that the restoration of COLA's for the nurses on special salary rates will be a positive step towards keeping pay comparable to the private sector.

IV. Financial support for education needs to be provided.

The tuition reimbursement legislation passed last year was a good step towards this goal and its effectiveness and implementation will need to be watched.

V. Increased support services.

By support services NOVA means other scarce health professionals and established health occupations such as pharmacists, ward secretaries, respiratory therapists, etc.

Staffing levels for support staff need to be increased. Nursing positions that are needed to provide nursing care should not be converted to create these support services positions.

NOVA further opposes the AMA's proposal of establishing a new category of worker--the Registered Care Technician. VA nurses say give us improved and consistent patient support services and we will care for the patients.

In conclusion Mr. Chairman, the nurses of the Veterans Administration believe strongly in the mission of our agency and ask that when you legislate our mission please legislate to give us the resources to fulfill it.

Thank you Mr. Chairman. I will now be happy to answer any questions.

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TESTIMONY OF

PAUL W. SCHAFER, M.D.

EXECUTIVE DIRECTOR

NATIONAL ASSOCIATION OF VA PHYSICIANS (NAVAP)

AT THE HEARING

BEFORE THE

COMMITTEE ON VETERANS AFFAIRS

UNITED STATES SENATE

SEPTEMBER 9, 1988

My name is Paul W. Schafer. Though I am employed full-time by the VA as Chief of Thoracic Surgery at the Washington, DC VA Medical Center, I speak here today in a strictly unofficial capacity as Executive Director of the National Association of VA Physicians (NAVAP). I was formerly Chief of Thoracic and Cardiovascular Surgery at the Walter Reed Army Medical Center where I trained a whole generation of the Army's surgeons who served with distinction in those specialities in Korea and Viet Nam. Prior to that I was Professor and Chairman of the Department of Surgery at the University of Kansas School of Medicine. My present academic appointment is Professor of Surgery (VA) Georgetown University. My government service, both military and civilian, and my private sector experience, academic and otherwise, have spanned the past half century. The last nearly 25 years have been spent in service to the Veterans Medical Program. I present my credentials as a reference for a professional institutional memory not all that easy to come by in recent years as Administrators, their Deputies, and Chief Medical Directors have moved rapidly into and out of the System.

We are appreciative of this opportunity to present our perceptions concerning the budget crisis and the effect it is having on the care of veterans and on the health care providers who serve them. I would also like to express my gratitude for the opportunity to serve deserving veterans very much in need of first class medical care, to carry out fundamental biological research, to teach medical students, to train post-graduate house officers, and to be part of a health care team with an esprit de corps derived from values based on merit and health care decisions of the highest quality uncompromised by monetary distractions. Coming from a background in the competitive, mercenary, entrepreneurial world of academic and private practice; first at Walter Reed and then in the VA, "Oh, what a joy it was to do for patients the very best that could be done without having to make decisions based on what it was going to cost." And to be able to do research and to teach based only on merit and competence. Not surprising, the esprit de corps. I submit to you that my patients have received care that will match that the most affluent could buy in the best of the private sector and care better than most receive elsewhere. And my service in the Veterans Medical Program is not a singularity.

Unfortunately such a bright picture will not much longer exist unless present day realities are addressed and long overdue changes are brought about. Time available in this forum will not permit more than a thumbnail sketch of these perceptions but perhaps by looking at the history of the Program we may avoid having to relive some of its past horrors. The Veterans Administration came into being July 3, 1930 during the Hoover Administration when several national functions pertaining to veterans were consolidated together with the Veterans Bureau as a new Agency. Having been Head of the Veterans Bureau for the prior seven years Brigadier General Frank T. Hines became Administrator of the New Agency. Dr. Charles M. Griffith became its Medical Director in 1931 and served in that post until 1945, longer than any other person. It is a charitable characterization to say that veterans' medicine up to World War II was practiced under conditions which would not assure a continuing diffusion of the highest standards of medical care throughout the system. Veterans' Medicine as viewed from the outside appeared to be a tight little world of veterans' benefits, veterans' forms, and military-like transfers of physicians between stations -- a world isolated from the rest of American medical practice, research, and education -- a self-imposed parochialism. VA physicians were not even accepted into the brotherhood of organized medicine. The American Medical Association (AMA) not only denied them membership, it opposed federal medical care for veterans except for strictly defined service connections.

World War II became a test which the Hines-Griffith VA leadership failed. During the War, American citizens on the home and battle fronts read about, saw, or experienced a variety of dramatic advances. Among these were: the effective use of penicillin and blood plasma and other blood derivatives; new techniques in neurosurgery, chest surgery, and plastic surgery; new treatments for neuropsychiatric ailments; speedier convalescence of the wounded; improved prosthetic devices for amputees; new drugs for tropical diseases; and the saving of the lives and even restoration to social and economic usefulness of paraplegics and quadriplegics. The American people, many in Service and many with family members in Service, were becoming increasingly knowledgeable about medical progress -- medicine's mystery was gone. Americans were directly concerned about veterans' care, their motivation to evaluate and criticize was high. It was not surprising that the quality of VA medicine came under fire by the print media, further arousing public reaction. It was later said, "Medical treatment was so far below standard that the newspapers were beginning to note the smell." Before the War was over this thing was going to blow up into a first-class nationwide scandal of bad treatment, costly blunders, and administrative incompetence. The situation was a perfect example of bureaucracy at its worst.

In 1945, with the War ended, VA hospitals were filled to overflowing with sick and disabled men and were critically short of doctors because of Civil Service red tape and the bad repute of VA medicine. The predicted scandal was at hand. President Truman tasked General Omar Bradley to straighten out the mess. To head up VA medicine Bradley brought with him Major General Paul Hawley who had been European Theatre Surgeon General. Convinced that the new VA leadership was serious about taking VA medicine out from under the Civil Service, a firebrand Chicago orthopedic surgeon, Northwestern University Professor Paul Magnuson became part of the team. The legislative instrument designed to free VA medicine, Public Law 293, was passed almost unanimously by the 79th Congress just before it adjourned for the 1945 Christmas and New Year Holidays. All that remained was the President's signature before January 3, 1946 to prevent its nullification by pocket veto. The serried ranks of the Civil Service Commission were not about to go down without a fight. The 72 hours spanning the New Year 1946 saw a high stakes battle between Mr. Arthur S. Fleming of the Civil Service Commission and President Truman's Assistant Zimmerman on the one side opposing Bradley, Hawley, and Magnuson. The last arguments in the struggle took place in the President's Office the afternoon of January 2. Later that afternoon the President signed PL 293 into law. This action, though it brought countless benefits to VA medicine and to America's veterans led ironically to the many problems being in part addressed today. To understand this circumstance one must look to the early implementations of the new law. Central to the new effort was what was to become known as the Hawley/Magnuson Plan. It can be traced to a five-page double-spaced memorandum on Dr. Magnuson's personal letter stationery which is now in the Archives of Northwestern University. It's author described the Plan as follows, "This is what I believe General Hawley has in mind for the immediate future for staffing of Veterans Hospitals and for cooperation with teaching institutions. I took Hawley to lunch and after the waiter had cleared the table, Hawley went over the plan with a pencil underlining sentences for emphasis, adding a word or a clause here or there to strengthen the statement. He put his big "PRH" on every key paragraph. This was it, the *modus operandi* of what was to be known as the Dean's Committee Plan." Its official counterpart is General Bradley's famous January 30, 1946 Policy Memorandum #2 which these 42 years later remains unrevised. Such informal, often personal, maverick initiatives, allowed the job of caring for America's veterans to get done, little worry being expressed about the way government usually did its business. Blind faith of the parties concerned is evidenced by the fact that not a single document was struck which identified and bore the signatures of the officials having legal competence to commit the government and the medical schools. Much of the totally new look of VA medicine in the coming years was due to "gentlemens' agreements". Though many Agency-wide instructions such as manuals, circulars, technical bulletins, directives, memoranda, interim issues, etc. have been promulgated over the years, there has been little modification of the basic principles and procedures first cited. We thus today have an Agency with a vital mission of caring for the Nation's veterans, second only to the Department of Defense in the number of its employees, including those who are in Title 38, who work under a set of never published nor adequately promulgated conditions of their employment. But from these auspicious developments, great and good things did flow. Most importantly returning World War II veterans did receive the best of care. One must read the documents of this era for a sense of the energy, excitement, and pride which went hand in hand with these good works. Particularly recommended are:

1. Ring the Night Bell, The Autobiography of a Surgeon, by Paul B. Magnuson, Little, Brown and Company, Boston and Toronto, Copyright 1960, Library of Congress Catalog Card No. 60-6031 - First edition. This is now available in paperback from the University of Alabama School of Medicine Press, 1986.
2. Medical Care of Veterans, ...to care for him who shall have borne the battle........ Published by The Veterans Administration 1967, U.S. Government Printing Office, Washington: 1967. This is essentially the work of Mr. Robinson E. Atkins who was associated with the Department of Medicine and Surgery from its inception. To a great extent he was one of the guiding forces in the growth and development of DM&S as it is now recognized. His official title from May 1946 on was Executive Officer in the Department of Medicine and Surgery. In that position he acted as principal administrative advisor and top assistant to VA Chief Medical Directors Hawley, Magnuson, Boone and Middleton.
3. VA Medical Program in Relation to Medical Schools, U.S. Cong. 91st 2nd Session House Committee Print No. 170, by Benjamin J. Lewis. Prepared for the Committee on Veterans' Affairs, U.S. Government Printing Office, Washington: 1970. This volume is essentially Dr. Lewis' Ph.D. thesis for the School of Government and Public Administration of the American University, Washington, DC. Dr. Lewis was an employee of the Veterans Administration for more than two decades and the work reported in his doctoral thesis represents five years of research, documentation, and analysis of the affiliation relationship between hospitals of the Veterans Administration and the medical schools of America. Though he was an employee of the Veterans Administration, Dr. Lewis' approach is a completely independent one, with no restraints on expression or on findings.

My reason for review of those times is that one will surely come to see the present time with a frightening sense of Deja vu. Though today's Veterans Medical Program is a far cry away from its sad World War II state, it has lost much of its bright promise of the 50s and the 60s. And the reasons for this are not all that dissimilar from those which caused its earlier affliction.

The first of these is money -- far too little of it. For years now the Agency's leadership has been unreasonably low in making its estimate of the amount of funding needed properly to carry out its mission, this underestimation often being on orders from the Administration itself. Regularly the Administration's Office of Management and Budget aggressively slashes whatever requests have been made and with about the same regularity VA Administrators have been less than vigorous in their protests of OMB Passbacks. For at least the past 12 years successive Presidents have sent a budget message to the Congress which has just not adequately reflected the needs of the Veterans Medical Program. For eight years the present Administration has poured unimaginable treasure into the Budget for our Department of Defense, never once seeming to recognize its obligation to care for its veterans as being an integral part of the cost of war; indeed, it has been said that in reality veterans are the DoD's only product. Honoring War's dead in photo-opportunities is no substitute for honoring the Nation's contract to care for those who survive. The fate of civilizations like that of the Romans, which in the end failed to honor its triumphant legions, awaits those who repeat the same mistake. Let ours not be one of them.

Cognizant of such inadequacies in the President's Budget, the past two years several of the Veterans Service Organizations have presented to the Congress an "Independent Budget" which has more realistically addressed current services needs with here and there modest funding enhancements. NAVAP has on each of these occasions joined in support of these budgets. Regularly the Congress has ended up appropriating more funds for Department of Medicine and Surgery Medical Care than the amounts requested by the President. But the fact remains that for the past 12 years as more and more new demands have been placed on the Program, funding in deflated dollars has been straight-lined; indeed, the Budget for Fiscal Year 1989 provides for only about 1/2 of the predicted inflator which is already recognized as an underestimate. As if this were not enough we now learn that with the VA Appropriation being grouped together with other Agencies in the HUD and Independent Agencies Appropriation that another government agency in this group, the National Aeronautics and Space Administration, has been given $25,000,000 of the VA's Medical Care funds to support its space shuttle program. At least this funding hazard should be minimized with elevation of the Veterans Administration to Departmental status. But all this having been said the fact remains that more money is needed if veterans are to receive the first class health care they need and deserve. There must be a more adequate Emergency Supplemental Appropriation for the remainder of FY88 and a much more realistic treatment of FY89 needs; without which the present conditions which will later be identified may be allowed to progress to a point beyond retrieval. There is still time to salvage the situation but it does require action now.

But now as then, more money alone will not suffice for solution of the Veterans Medical Program's problems. **The Program's management must be subjected to critical scrutiny. Succinctly there is too much of it, and much of it is bad.** The sheer disproportionate numbers of persons employed in administrative roles and the inflated importance assigned to their roles in relation to the numbers and importance of direct health care providers is nearly at an obscene level. If this is allowed to continue, medical care of veterans will be hard to find in a Program that does virtually nothing but administer itself. Tables of organization have been created which imply equality as between the Chief of a Major Bed Service such as Medicine with the Chief of an Administrative Service such as Medical Media Production. With rare exception Facility Directors and their second in command, called an Associate Facility Director, ascend the ladder of advancement from the ranks of administrative services with the most senior direct health care provider, the Chief of Staff, being third in command. Leadership roles have for all practical purposes been careers closed to bright young men and women physicians who might otherwise prepare for them. The Agency is so fearful of identifying the background and origin of its Facility Directors and Associate Facility Directors that for 8 years it has failed to respond to NAVAP's request for such information made under the Freedom of Information Act. The last response we have obtained is dated January 25, 1980 and revealed that of 151 Facility Directors, 27 were without any academic credentials much beyond their high school certificates. It is assumed that this situation has improved but we have been denied any proof to support this assumption. But in addition to exclusion from management of the largest talent pool of persons most knowledgeable as to what health care is all about, we have had foisted onto us one unrealistic management scheme after another. Recently one was called Medical District Initiated Program Planning (MEDIPP). This scheme was thought to insure that direct health care providers at the grass roots level, given such a glorious input into definition of program needs and into the creations of policies, would supply top management in VA Central Office with a plethora of material which could then be used to persuade a doubting Congress. The Chief Medical Director who is most prideful of this program had forgotten that a year before MEDIPP was announced the only physicians serving as members of the 27 Medical District Executive Committees; namely, Chiefs of Staff, had been removed from the District Executive Committees' membership. The energies and resources directed into this ill-conceived MEDIPP program represent fruitless waste in what has now become a laughing stock.

But they never learn. Now we have Diagnosis Related Groups as a basis for Resource Allocation Methodology (DRG/RAM for short), a completely predictable failure; what would seem to be an unfulfilled Agency death wish which now appears to be in its last agonal convulsions. It is to hoped that new faces can be directed toward the application of meaningful management arts and skills. The private health care sector's fall-out from the decision to reference Medicare payments on diagnosis related groups and their singular length-of-stay indicator (LOS) is as nothing compared to what has happened in the Veterans Medical Program. The Agency's Me-Too, Knee-Jerk adoption of DRG's as its sole reference for managing the allocation of resources (RAM) failed totally to recognize fundamental differences in the public and private health care sectors. Even a new currency had to be created; work units rather than dollars, and these then had to be weighted (WWU). Thus was the stage set for the new game upon which everybody in the Agency was to focus their attention - not on a proper, full-time attention to providing the best possible health care for our veteran beneficiary patients. Oh, Yes, the game had to be laid out with rules which would allow curves to be drawn for each one of the 469 DRGs through high and low "trim points" so that individual patient's LOS could be said or could be made to seem to have earned the maximal WWUs, which could be aggregated into totals, which could be compared with the paper "earnings" of all 172 medical centers, which could then be assigned to groups based on their performance in generating WWUs in respect to the number of dollars ($) they had been allocated to spend. The annual grand finale of this new game, its Super Bowl or World Series, was said to occur when all of the individual group facility net gains and losses (WWUs/$) were tabulated and published with prizes and penalties taking the form of dollars ($s) to be made available to each facility to play the game (DRG/RAM) during the next fiscal year. And the driving emotional force in all of this charade was the sense of guilt created in the players, those who bore the stigmata of not having done their best and particularly in those who were actual WWU/$ losers.

This DRG/RAM management disaster has now been in place just long enough finally to be recognized for the damage it has caused, not the least reason being the precious scarce funds for patient care which Facility Directors, Regions and Central Office have diverted to DRG/RAM administration and to the hiring of an army of personnel considered to have expertise in playing the new game. Millions of dollars in medical care funds have been diverted to this purpose. Time, energy, and the focus of health care providers have been diverted to the game at the expense of patient care. Quality Assurance has been increasingly blurred by Utilization Review. Funds for DRG/RAM gamesmanship mean fewer health care FTEE, less support of clinical investigators and scientistis and research in general, less money for supplies and equipment, fewer hospital beds and less ambulatory, intermediate and nursing home care, delays, etc. for veteran patients, "Sicker and Quicker" discharge of veterans who have been unable to get into our hospitals; and perhaps, most of all, the creation of a reference for admitting, treating, and discharging patients that replaces the only valid reference; namely, what is best for the patient. In addition DRG/RAM has the real potential of making the patient's record a fiction rather than an accurate documentation of the patient's experience. NAVAP has repeatedly called for the termination of this travesty. We now represent that the time has come for all to recognize that DRG/RAM is a failure and should be eliminated. From the many telephone calls and letters which come into National NAVAP Headquarters with increasing frequency in each passing week, it is apparent that local facility managers play the DRG/RAM game by contradictory interpretations of its rules. The plight of individual VA physicians caught up in this pressure cooker experience illustrate a whole spectrum of Catch-22 possibilities. The following example is submitted for your reflection:

> *From the Memphis, TN VAMC: John J. McCaughan, M.D. is a prominent member of the social, academic, and professional Memphis community. He is a well-established and highly regarded vascular surgeon who trained under and succeeded Ralph Bowers, M.D. who was the first Chief of Surgery of the largest World War II Army Hospital as it became the Memphis VA Hospital after the War. Dr. McCaughan has developed and run one of the finest surgical services in the VA System. Imagine his shock upon being summarily removed from his position as Chief of Surgery by Memphis Facility Director, Mr. Kenneth L. Mulholland, Jr., a former male orderly, who charged that Dr. McCaughan had been insufficiently attentive and involved in the paper work production needed by their Utilization Review, Quality Assurance, nee DRG/RAM activities. Dr. McCaughan readily admits that he spent his time on running the Memphis VAMC Surgery Service to the best of his ability, rather than participating in what seemed to him to be senseless and wasteful gamesmanship with people who most times were so ill-equipped for the tasks they undertook that he wondered if they could distinguish between a coronary artery bypass and a vegetable patch. And irony of ironies, after last years' publication of National DRG/RAM Performance Statistics, Dr. McCaughan began to receive telephone calls from fellow surgery chiefs asking how his surgery service had achieved the highest net WWU/$ gain in the entire nation. As yet he has received nothing but dreck from his Facility Director, Kenneth L. Mulholland or his Chief of Staff, David M. Mirvis, M.D.*

In our last issue of NAVAP NEWS we warned our members as follows: *With this issue all NAVAP members should go on alert that this game can best be regarded as a mine field to be treated with great care. Know that facility managers are under tremendous pressure from VACO and Region not to reveal the terrible economic mess the VA is in. The new absurdity being promoted is that dollars are not required to improve the quality of care, only quantity requires dollars. As one NAVAP District Director puts it, 'This austerity program is ripping the guts out of the VA Medical Care System.'*

Though it is finally becoming obvious that DRG/RAM/WWU is a disreputable system that breeds manipulation and fraud, managers will continue to press it on you until this obscenity can be added to the long list of other misguided ill-conceptions. Do not be surprised if managers close their eyes and ears to all sorts of DRG manipulations that will make WWUs, and even unofficially condone or order (verbal) them until someone blows the whistle. When the powers that be call for blood, watch them scramble to find a fall-guy or gal. Don't be one!!!

Most importantly don't let this highly touted gamesmanship that is being played distract you from the reality that the Veterans Medical Program and our reason for serving in it has one overriding reality and that is to provide for our veteran patients the highest quality of care that can be achieved. Anything that *compromises this fundamental purpose should be regarded as dreck. The patient's medical record is a most valuable document which must accurately and completely define the patient's experience while under our care. Lay managers have many proper administrative functions which do not include patient care. Perhaps the time has finally come for entrance onto administrative career tracts to be reopened to bright young men and women physicians who do know the difference.*

And finally we come to the last item in our 3M kit of particulars. **We now add meanspiritedness to money and management** as not the least debilitating influence being felt in the Veterans Medical Program. Top VA Administrators threaten Facility Managers with dire consequences if they open their mouths about the current fiscal crisis they face. VA General Counsel exudes an antediluvian lack of sensitivity and its opinions reflect an arbitrary perspective that the Agency is always right and any one at odds with it, regardless of merit, is to be found in error. The Administrator's Office of Employee and Labor Relations views all Agency employees with a single hostile defensive attitude that brooks no distinction between a physician and a housekeeping clerk in the roles they play in a complex health care delivery organization. The Inspector General runs rough-shod through the Organization accusing physicians of malpractice, licensure defects, moral turpitude, drug abuse, and payola; and leaks these unsupported data to favored media sources which loudly trumpet these flawed charges which go unremarked as they later are proved on careful review to be essentially without merit. The Agency considers section 4108 of Title 38 U.S.C. to give the VA Administrator the absolute unfettered right to promulgate rules concerning the working conditions of all Title 38 personnel. These rules, such as are to be found in facility personnel offices, have never been formally published in the Code of Federal Regulations. They are a disorganized collection of all sort of documents with hand-written additions, hand-written cross-outs, revisions and portions that are cut and pasted, in short, such a confused reference, a hodgepodge, that it is a common occurrence for personnel officers to admit their inability to answer simple questions. Referrals of question to higher authority in Central Office is equally unrewarding with ambiguous responses being made after months of delay, if they are made at all. The Agency has stonewalled all efforts to have a meaningful set of rules published. In general, as they now exist, they would evoke outrage if they were to see the light of day. In most matters the VA acts as prosecutor, judge, and jury with the Title 38 professional having almost no due process or other rights. Almost half of the 13,000 physicians who are employed part-time by the VA have essentially no rights. They can be and are fired without notice, without cause; indeed, for no cause at all. Even physicians employed full-time and who have achieved "tenure" have essentially only the right to be employed, at least so long as other available pressures have not been brought to bear. It would certainly seem that the time has come for substantial constructive treatment of Section 4108 of Title 38 U.S.C.

These and many other considerations were discussed at NAVAP's Fourteenth Annual Meeting this past June 4. On being present and hearing such allegations, the managing editor of U.S. Medicine was moved to send a ten point questionnaire to all VA facility Chiefs of Staff. Their responses will be featured in the August and September issues of that publication. The texts of these articles have been given to me with permission to include them in my submitted testimony. This I have done. I am sure you will find them to be as revealing as I have.

We are also reliving events nearly identical to those which existed back in 1974 which were in large part responsible for the founding of the National Association of VA Physicians. Then, as now, the Uniformed Services were facing a crisis in the recruitment and retention of a sufficient number of high quality physicians to meet the needs of the several services. It was recognized that their salaries had become noncompetitive in the common marketplace from whence all physicians come. Legislativ initiatives were undertaken to obtain salary augmentation in the form of Special Pay for physicians. The VA on being offered the opportunity to join in this action responded that no such recruitment and retention problems existed in respect to VA physicians and thus opted out. The fact was that the VA did have serious physician recruitment and retention problems and these were addressed by the newly formed NAVAP which with major helpful assistance from the Veterans Service Organizations and the dedicated Committees of the Congress obtained passage of P.L. 94-123, which provided modest Special Pay for VA physicians and insured continuing first-class health care for veterans. A comparable result was obtained in 1980 by passage of P.L. 96-330.

We are now aware that the Uniformed Services are again facing physician recruitment problems of crisis proportions and that efforts are again underway to obtain legislative solutions. We do not know whether the Veterans Administration is either knowledgeable or interested in these developments. We do know that VA physicians have had a 25% loss of deflated dollar income since 1980 and that there has occurred an almost revolutionary change in VA physician staffs during this period, a change more than a whole order greater than that which has occurred in the Uniformed Services. It is illustrated in the histogram which you have seen as the last page of my submitted testimony and which I will only summarize here. By way of comparison the Navy's total physician loss for the years 1985, 1986, 1987 and 1988 (proj.) was 57, 56, 84 and 94 respectively. In startling contrast the average VA physician loss for the last 7 years has been 1,568 per year with peaks occurring in 1981 and 1982 as a result of P.L. 97-72 which, without a grandfather clause, changed the method of computing annuity benefits for part-time service, a most egregiously unfair and damaging piece of legislation that continues to have major negative effects. A second peak has just been experienced in 1986 and 1987 which years represent losses of 1,924 and 1,852 respectively. These result from the provision in P.L. 96-330 which caused 50% of physician Special Pay to be included in calculation of annuity benefits for those who retire subsequent to October 1, 1985. The next disastrous loss will occur after October 1, 1990 when 100% of Special Pay will be included in annuity benefit calculations.

As the graphic clearly shows these losses over the last several years have included a very substantial number of highly qualified, experienced, senior physicians, a total of 5,477 to be precise. Though younger, less experienced physicians have been hired to keep rosters filled, during the last six years almost 4,000 of them have served for less than 2 years, many for less than one year. Many have served for only a short time beyond 2 years, waiting only until the right contacts had been made for them to enter private practice.

These changes have been analyzed in some detail for the last year for which we have complete computerized records. During calendar 1987, 1,832 physicians left the System and 1,888 were hired. But this numerical replacement was far from a quality replacement. Among the 1,832 who left, our records show that 575 were senior, experienced physicians, 440 of whom were certified by their professional boards, a distinction only a handful of their 1,888 replacements brought to their service in the Veterans Medical Program. Diminished quality in psychiatric staffing is so severe that this field will require designation as a scarce specialty if improved recruitment is to occur. Though money does not alone reflect quality, it is still axiomatic that you get what you pay for. It should be noted that approximately a third of the replacements were hired at significantly low salary levels and the track record for their predecessors would clearly suggest that many will stay only until they have passed their board examinations and have been certified in their specialties. And this is in no way meant to be critical of them, it is merely to underline the fact that only a few can be counted on to elect a career of service with the Veterans Medical Program. These are bright young men and women physicians who above all should be in all possible ways encouraged to serve veterans' needs. What we are now exposing them to hardly serves that purpose:

* In this last quarter of the fiscal year 1988 they work in VA medical centers that have very nearly run out of money.

* They see such a severe shortage of nurses that wards have been closed; though this is not admitted; and they see medical, surgical, and other intensive care facilities with patient stations that cannot be used.

* They can no longer be sure that ordered medications are actually being administered to their patients in need.

* They see staff and resident physicians and they themselves under pressure to make critical diagnostic and therapeutic decisions about their patients more relevant to the WWU/$ net result than what is really in their patient's best interest. "Sicker and Quicker" discharges are now a reality.

* They are involved in failed urgent and emergency communications that are placing patients in jeopardy. Without an adequate support staff, not even anyone to answer the telephone, reliance on answering machines and pagers has been the order of the day. No funds are available to repair or replace these devices as they fail with increasing frequency.

* At one tertiary care VAMC they would see the following deficiencies:

  *20 of the 25 kidney dialysis machines are obsolete and inadequate.
  *G-I endoscopy equipment is outdated and constantly breaking down.
  *Respiratory therapy ventilators are largely obsolete. They are unsafe for patient use and when used make it almost impossible to wean patients off.
  *Cardiologists feel they had an avoidable death, a veteran who could have been saved if their two aortic balloon pumps had not been broken down.

* Laboratory Services can no longer perform many of the tests needed by their patients. There is no money to buy the needed supplies. Their patients wait days for those that are still permitted, only to find that some of these cannot be done because the equipment is broken and can't be repaired or replaced -- no funds. The other day a pathologist told me that his service could not even buy a grindstone to sharpen their knives and the one they have has been worn so smooth that it no longer is useable. That's akin to arming a combat infantryman with a toy gun.

* Pharmacy Services can dispense only a much curtailed list of therapeutic agents. They see physicians including themselves being placed in the onerous position of not writing prescriptions to meet their patient's needs because there are not funds to fill them.

* Radiological Services have placed limits on the diagnostic services they are able to perform. Funds are just not adequate for supplies and costly equipment maintenance.

* Many bright promising young men and women are appalled as they witness a break in the VA's long tradition of funding clinical investigators and scientists. Even established investigators are having 80% of their requests disapproved by VA Central Office. The VA quite understandable takes great pride in its Nobel Laureates whose works were so generously supported in the 60s. Without more support now there will be no pride in the future.

* But perhaps most disheartening and most hazardous for their veteran patients, orders are now out that outpatient appointments are to be curtailed and those that have to be made should be scheduled as far into the future as possible. Some veterans under these stringencies are going to be lost to follow-up and some will have suffered progression of their diseases beyond the point of no return. Of those patients who do get appointments many wait for hours in clinics because of the sad, chaotic state of medical records and their general unavailability when needed.

* But perhaps most significantly they will have served with a staff of health care providers who each day wonder what next will befall this wonderful system to provide

first-class, high quality care for veterans. They question if we are not moving to a time when the practice of medicine for veterans will validly be regarded as being second or even third-class, merely an alternative to the care of the indigent in the charity wards of public community hospitals.

Can you fault a bright young man or woman physician who plans for a career elsewhere than in the Veterans Medical Program? And that my friends is the challenge which together we face. How to turn this thing around?

And maybe the time of Veterans' Affairs being elevated to the Cabinet level is the time to do it:

* There has to be more money.
* Effective management practices must be put in place. Too many inept cooks spoil the broth.

* Section 4108, Title 38 U.S.C. with its unfettered delegation of authority must be replaced by modern personnel policy structures.
* And, the new Department of Veterans Affairs must have leadership of character and competence akin to that of the Bradley, Hawley, Magnuson triumvirate and the early CMDs who followed. NAVAP suggests that many voices should be heard in the selection process for CMD, with that of the Association of American Medical Colleges being only one of the many.

And now you might ask, if things are as bad as they seem, why even try for a fix? And the answer to that question is that most of what ails the Veterans Medical Program is but a reflection of the larger society in which we live. We need to make every effort to have the VA Health Care Delivery System live up to its prior promise because it has the potential for becoming one of the models which America must have if we are to meet the unmet health care needs of all of our citizens. In our pluralistic society some of its features may be found more attractive than those of the failing Health Maintenance Organizations of the private sector, the Insurance Companys' Money Machines or the Health Care Enforcement Plans of Corporate America.

And the action needed now should not be delayed until one day, someone is going to be found dying on a street in the Nation's Capital, perhaps having tried to stay alive on a grate on a freezing January night. And in his meager bag of possessions there is going to be that ribbon with the blue -- and the white stars -- and the medal hanging at the end of it. And we will have allowed a guy who may have tried to go to the VA, and he was one of the lucky ones, a guy who won the Congressional Medal of Honor and didn't have a "service-connected" disability. And he was turned away because for him there was no available room at the inn and he'll die on a grate -- the electronic and print media will have a feeding frenzy -- and even Right or Left leaning ducks with only one foot will run from this responsibility.

Again I thank you for this opportunity and I will try to answer any questions you may have.

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By Terry Jemison

Thomas Turnage

WASHINGTON—Waning hospital budgets have been the hot topic in regional meetings conducted by top Veterans Administration officials this summer, with some hospital administrators forecasting a fiscal crisis by fall as they enter the final months of the fiscal year.

Following their meetings with the field, VA medical officials in Washington began discussing a temporary suspension of their workload-based resource allocation methodology (RAM). That would allow them to move funds around the system to provide quick fixes in geographic hotspots where facilities claim to be on a path toward multimillion-dollar shortfalls.

Chief medical director Dr. John A. Gronvall said a small task force is synthesizing dozens of options—reportedly including the RAM suspension or vertical cuts by eligibility class—that have been put forth through the regional meetings with hospital chiefs as well as meetings of various internal and external advisory groups.

He said he would have "prioritized recommendations" to deal with shortfalls this month. "...We'll be in good shape to say here are a series of steps that we think could be taken to harmonize the amount of money we have with program responsibilities," Dr. Gronvall said at one meeting.

Symptomatic of the current atmosphere in Washington to protect the bipartisan deficit-reduction agreement, an infusion of new resources was not promising. The White House budget office reportedly has rejected the medical department request that VA ask Congress for a supplemental appropriation for fiscal 1988 that would bail out some financially strapped Veterans Administration hospitals.

The financial outlook for the next fiscal year, which begins October 1, similarly looks unappealing to VA managers, who blame rapidly escalating prescription drug costs, new programs or benefits authorized by Congress without accompanying funds, and political and legislative requirements that the hospitals maintain certain staffing and bed levels—and in some cases, certain specialized services—at any cost.

The impact is compounded by requirements that VA hospitals absorb pay raises and added health insurance costs as well as arbitrary "productivity gains," which are billed as projections of doing more with less, but actually constitute a 1 per cent annual across-the-board reduction in resource allocations.

VA's top political guard is unsympathetic. VA administrator Thomas K. Turnage bragged publicly about the chilling effect of his site visits to the facilities on hospital directors who are prepared to enumerate their decrements in service, but who begin "covering their tracks" when he interrupts with the administration's message that overall funds and staff levels are up and authorized beds are vacant.

At a recent public meeting of policy advisors at VA, Turnage related such an anecdote of a backpedaling hospital director. "While I'm not a vindictive man," Turnage grinned, "they know I have a long memory."

Turnage's deputy, Thomas Harvey, under questioning by VA physicians following a speech to the National Association of VA Physicians a month earlier, acknowledged that a problem with Turnage's site visits is that career employees tend to tell the administrator what they think he wishes to hear, which fuels Turnage's public pronouncements about the system's health.

However, given an opportunity to speak

out in the press without attribution—through a *U.S. Medicine* survey of field facilities' medical leadership—chiefs of staff said the Reagan administration's message that budgets are adequate because high-eligibility veterans are not being turned away is a red herring.

In many cases the hospital's equipment funds and maintenance and repair accounts have been pillaged to be able to continue business-as-usual patient care, they related (see related story on field survey).

Some congressional leaders this summer were fighting for a supplemental appropriation, while others were skeptical, as the VA "fiscal crisis" is not universally accepted as a fact throughout Washington.

One high-ranking appropriations committee source observed that he has seen no evidence of anything unusual in the VA's fiscal health this summer. Besides, he said, the RAM model by which VA carves up his panel's funding is merely an invention of the VA that can be washed away or modified with a stroke of Dr. Gronvall's pen.

In other words, he explained, VA can act administratively to move money around within the system to take care of any troubled hospitals—"robbing Peter to pay Paul." At authorizing committees, staff members also agreed that such a reprogramming would not require congressional approval.

Further, it is generally acknowledged that the resource formula has worked in tandem with space-available eligibility rules to yield serious inequities in access. For example, two veterans of the same non-service-connected eligibility level may find dramatic differences in availability of care for the same condition if one lives in the Northeast and another lives in the resource-constrained Sunbelt.

A member of one of the authorizing committees who has championed more funds and services for veterans, Rep. Lane Evans (D., Ill.), is squarely in the middle of the rationing dispute and is asking the same reprogramming question.

He has an unusual dual interest in the matter as the chairman of the Oversight and Investigations Subcommittee of the House Veterans Affairs Committee, while also a representative of constituents in the region recently affected by one of the first publicly identified eligibility cuts, at the Iowa City, Iowa, VA hospital (the hospital lies just across the state line from Rep. Evans' Illinois district).

Local VA officials confirmed that 500 outpatients in Rep. Evans' district were affected by the policy change, and while he has been assured that Iowans can be taken care of at Des Moines medical center while his Illinois constituents can receive care at a Peoria VA outpatient clinic, he thinks the case illustrates a fundamental problem of equity in access.

"Veterans benefits essentially are dependent upon where you live in the case of these non-service-connected Category B and C veterans (the two lowest income-based eligibility levels)," Rep. Evans said in an interview.

"...Five hundred veterans living in my district get less benefits than veterans living in another state."

"We're just shifting these veterans from one facility to another," Evans said. "I don't know how that saves us money; it certainly does not provide for real coherent planning or delivery of services to these veterans."

However, there is some sentiment within Congress and in the VA that if a hospital is facing a $4 million deficit in the fourth quarter of this fiscal year, its director probably has not paced his expenditures by controlling workload, such as limiting admissions to only the highest-eligibility veterans.

For example, most non-indigent, non-service-connected veterans have no statutory right to care, and while they may be taken care of on a space- and resources-available basis, systemwide figures (which do not reflect possible geographic crises) for last year show that about 7 per cent of applications for medical care fell outside of this mandatory care category.

Yet at the same time, VA's medical leaders have been vigorously implementing a defensive public relations strategy of discouraging the field hospitals from doing as the Iowa City hospital has done—publicly acknowledging policy moves to ration care to only higher-eligibility veterans.

Some view that as a mistake, believing that acknowledgment of rationing will bring about more political support for initiatives like one recent proposal that would have diverted NASA space station funds to veterans health care.

On the other hand, some VA medical officials fear that setting such black-and-white policies as refusing new appointments to lower-eligibility veterans will never be undone because of their potential attractiveness to the White House budget office.

Given the prospect of tight resources continuing throughout fiscal 1989, the dilemma was at the center of a hot debate within VA's medical department and its Field Advisory Council in July.

What some call a "Washington monument" exercise—a symbolic focus on policies to actively ration care on the basis of eligibility category—could lead to acceptance of the threat on a broad scale, some officials warned.

"I don't want to do permanent damage to the veterans system," Dr. Gronvall said, explaining his aversion to the "Washington monument syndrome."

"I don't want to just go around crying wolf," he said.

The field advisors are looking at a combination of options, such as cuts in medical education support.

"What we've done this year is cannibalize our equipment money and some of our discretionary funds," Dr. Gronvall said. Now those options no longer are available.

"I want to be honest about the context," he told another group of outside advisors at a subsequent meeting, noting that things are tight in the private sector as well.

"I don't want anyone to think we're overdoing the problem."

For the time being, one high-ranking operations administrator told *U.S. Medicine*, instead of announcing broad policies such as "no Category B and C care," hospital directors are expected to put the word out quietly to staff members involved in medical admissions and appointments scheduling, then ration access case-by-case based on eligibility findings.

However, so-called "drop-ins" pose a problem observed by another staff member, who said that once a veteran presents for evaluation and a physician has become involved in the case, patients tend to eke through the best eligibility triage.

For next fiscal year, based on budget marks already sent to the field, a shortfall would amount to between $540 and $800 million systemwide if workload reflects current levels of need coupled with new programs.

Within that figure is $250 million in new but unfunded statutory benefits just added by Congress—including beneficiary travel and nurse pay (see related story)—as well as the anticipated absorption of pay raises, employee health benefits and specified AIDS programs.

Field officials have complained about requirements that they maintain minimum numbers of beds (required by law) and a set number of staff slots, as decreed annually as part of the appropriations process. Medical leaders in Washington, warning these hospital directors that Congress watches those numbers carefully, have been reluctant to allow directors to scale down operations that way.

However, *ad hoc* controls over "quantity of care" may be developing locally in ways unknown by VA medical officials in Washington; an independent mail survey of VA chiefs of staff conducted by *U.S. Medicine* indicated additional facilities—beyond those like Iowa City, Boise and San Diego that are listed officially—are limiting access.

"We have been forced by fiscal crises to restrict care of the non-service-connected patients even past the point of current eligibility regulations," a southern hospital's chief of staff said.

"Why seismically reinforce a VA hospital at a cost of several million dollars when veterans are dying while awaiting at times low-cost needed treatment or restricting drugs as a cost-savings method?" he asked.

While only a few chiefs of staff from among the 41 survey respondents said flatly there is no fiscal crisis (many did not explicitly address the question), most said that whether non-service-connected veterans are being turned away is not a reasonable yardstick of the state of the VA system.

"'Turning away' is a quantity issue," a midwestern chief of staff noted. 'The crisis exists in quality of care.... The crisis we are experiencing reduces our care to marginal, our equipment to old and worn, and methods and experience to inferior."

The chairman of a dean's committee for one VA hospital wrote top VA medical officials in Washington to complain that the agency has refused to allow the affiliated VA hospital to close an organ transplant program—despite VA's rescission of the extra funds it had promised for the program's operation. In general, quality of care at the facility is in jeopardy, the dean of the prestigious medical school said.

Congressional committees have varying levels of empathy.

Rep. G.V. (Sonny) Montgomery (D., Miss.), chairman of the House Veterans Affairs Committee, has strongly advocated a supplemental appropriation. He was so swayed by reports of quality decrements at one facility that he inserted a nurse's plea for more staff in the *Congressional Record*. "The end of the fiscal year is far away," the Ward 7C nurse at an unidentified northwest hospital wrote, "and patients are in danger today."

"On May 19," she wrote, "I worked a 10 1/2-hour shift nonstop. One patient had chest pains.... While I spent so much time with him, the other 21 patients were taken care of by my one support staff. Nine a.m. medications were not delivered to all patients until after noon. One of my surgical patients did not receive a needed dressing change."

"On May 22, only three staff were assigned to care for 36 patients ... One patient had been on the wing for 24 to 30 hours and had surgical dressing ... ordered for each shift. None had been done since he transferred from his old ward the day before.

"He has a colostomy stoma that opens directly into his incision and stool often gets into the wound. I found a patient who had had an IV hung 30 hours earlier. It is anyone's guess when that bag had quit running; his arm was red and painful...."

A senior physician at the same facility contacted by *U.S. Medicine* voiced similar concerns. "Waiting for the system to fail is too late because there is a long lag to fix it, and when it fails, eligible vets will go without services.... We simply don't have the money to give critical life and death care in some instances."

The VA medical department's Field Advisory Council reportedly suggested that Dr. Gronvall consider policies to manipulate workload in part using the eligibility screening opportunities presented by the new VA patient "means test" as at least a partial solution to budget deficits.

Under law, VA is required to furnish hospital services to service-connected veterans and to non-service-connected veterans whose income is less than $15,833 (or $18,999 for a married couple). The other non-service connected are categorized into two other income brackets, the higher of which involves copayment.

Rep. Evans said he is concerned about what this summer's fiscal problems at certain hospitals portend for the future of VA health care.

With VA "struggling to tread water in terms of current level of services," how will it meet the steep demand curve approaching with the aging World War II veteran? he asked.

In an earlier statement at the time of the Iowa City cutbacks, he published a news release in his local district, asserting, "This is nothing but an attempt to balance the budget on the backs of the veterans."

Several days later, VA administrator Turnage responded that the "desperate voices" complaining about balancing the budget on the backs of veterans "are the same guys who voted for the compromise...for this year's budget arrangement."

Criticizing the exploitation of a local dispute for political purposes, Turnage said the nation needs more statesmen and fewer politicians. "I think it's political garbage," Turnage said. "I find it reprehensible."

Rep. Evans said it shows why VA needs Cabinet level status, to reduce the political leverage instilled in the agency by White House budget authorities.

"Why is there a summit agreement?" Rep. Evans asked. "Because of Gramm-Rudman. I'm a member that did not support Gramm-Rudman originally because I thought it would lead to this kind of situation in which important programs like this one are forced into...cutbacks."

Quality Worries VA Chiefs Of Staff

(First in a series)

WASHINGTON—A U.S. MEDICINE survey of chiefs of staff throughout the Veterans Administration medical system evidenced significant concern about erosion in quality of veterans health care.

"We are being slowly strangled to death," a Midwest chief of staff summarized.

VA The State of the System

Quality is jeopardized by an inability to replace a broken bronchoscope or sigmoidoscope and an inability to offer salaries needed to retain excellent doctors, nurses and medical administration clerks, the chiefs of staff said.

Basic supply needs are not being met in some locations, with expensive drugs sometimes out of reach—or long delays for procedures that require special supplies, such as joint replacement or lens implant after cataract surgery.

For others, the fiscal squeeze means inadequate funding for halfway houses for effective substance abuse therapy or barriers to outplacement of veterans requiring extended care.

Even in the hospitals where the medical leadership felt resources were adequate, there is a nagging concern about such areas as decreasing opportunities for continuing education.

Forty-one chiefs of staff responded to the survey, representing about a fourth of VA's 172 hospitals.

Many showed political sophistication in their understanding of the dynamics of policy change, such as the New England chief of staff who forecast, "Congress will not deal—on its own—with the issue of progressive horizontal cuts versus restructure of the system through vertical cuts (in hospitals and programs). This failure will place the system in great jeopardy because it will create a perception and reality that the VA is 'not as good' as the private sector."

He proposed a 17-point plan to deal with expectations that Congress will not provide appropriations beyond an inflation-adjusted 1977-comparable level; he suggested such moves as a campaign to convince Congress that an emphasis on beds is destructive and a medical department initiative to shrink the system based on maintenance of quality of services.

A Western chief of staff said decrements in quality are visible not just in clinical errors but also in missing charts and lab reports, as well as "...long waits (and) very long periods between clinic visits to accommodate greater numbers of patients with concomitant deterioration of proper patient followup."

A Midwest chief of staff said his pessimism is reflected in unfunded equipment needs exceeding $1 billion systemwide. "*In* economically depressed areas, VA health care is the only health care available, and this safety net now has many holes, is frayed at the edges, and is in danger of collapse," he wrote.

On the other hand, numerous other facilities did not forecast "gloom and doom," though few if any were consistently upbeat about the trends they are observing.

Several other patterns—to be examined in future issues of *U.S. Medicine*—also emerged from the survey of the state of VA health care: the medical district planning program engenders enormous hostility ("a joke," "a sham," "dominated by the regional director's lay staff"); the resource allocation methodology (RAM) funding formula, while often suspect, has both champions and critics, the latter alleging widespread gaming and abuse of the process; and chief medical director Dr. John A. Gronvall enjoys wide respect for making the best of a perceived no-win situation of conflicting pressure from VA political appointees, the White House, the Congress, and veterans groups.

The survey was designed to stimulate narrative and suggestions, and thus did not yield statistically quantifiable yes-no views of the budget, yet certain areas of consensus were suggested. For example, chiefs of staff surveyed frequently contested the premise held by certain political defenders of current budget request levels that funds must be adequate if eligible veterans are not being turned away and if significant amounts of care are being devoted to non-service-connected veterans.

Many respondents noted that most of the non-service-connected veterans cared for are in the lower economic bracket for whom VA is required to provide care.

While VA has for years used the adjective "eligible" in cloudy policy statements such as "no eligible veteran has been denied care for agent orange-related disease," the chiefs of staff surveyed frequently sought to clarify the administration's contention that no eligible veterans are being turned away from VA hospitals.

Recognizing statutory distinctions of eligibility categories between when VA *shall* provide care and when it *may* offer care, one Southeastern hospital's chief of staff brought the matter into clearer focus this way: "*Obligatory* eligible veterans are being treated, but non-service-connected, seriously ill, poor, combat, *eligible* veterans are turned away daily."

"We are not, unlike most other sections of the country, able to provide outpatient care to veterans other than those who are entitled by law and those who require follow up treatment for recent hospitalization," he explained.

"There appears to be *absolutely no interest* in VA Central Office, the Congress or the White House to attempt to offer or deny treatment to veterans even-handedly throughout the country. We daily turn away veterans who have been treated for years at northern VA hospitals," he added.

He pleaded for leaders to insist that Congress and the executive branch "define *what* they want done to whom and where." Programs, eligibility and treatment sites, he said, "must be adjusted down on a need, not political, basis."

Yet a Northern hospital's chief of staff also recounted serious resource constraints. "I have seen denial of services to non-service-connected veterans and shuffling and shunting of service-connected veterans to tertiary care hospitals for lack of timely replacement of common diagnostic equipment such as echocardiograph, EEG, etc.—fiscal crises plenty during the last three years."

Even the calmest voices are concerned that adapting to fiscal austerity has sometimes not kept clinical priorities highest, taking a toll in equipment resources and medical education as well.

"Crisis? No. Limitation in spending and conserving resources? Yes," the chief of staff at a Midwest hospital said.

"We have an elegant new fire station and are remodeling or removing the greenhouse when we need to have a clinical improvement addition and ward remodeling, which keep getting delayed."

Another Midwest chief of staff said his facility has been able to care for all veterans applying for medical care, but not without a price.

"The staff of the hospital has been working harder and harder, solely to treat patients," he said.

"They have had to give up time that could have been devoted to clinical research and to academic pursuits.... Teaching medical students and residents has been eroded, ever so slightly, but noticeably over the past three years."

While most rejected the idea that admission rates for low-eligibility patients are a good yardstick for measuring fiscal health, a mid-Atlantic region chief of staff said only about 20 per cent of his inpatients are service-connected veterans, and only about 4 per cent are in the hospital for their service-connected problem.

Another chief of staff who had seen no evidence of fiscal crisis sympathized with hospital directors who must spend money "within its category," noting he has seen wallpaper placed over marble.

"We cannot spend 'construction' money for 'patient care' programs; thus, they have to do something with it," he commiserated.

Even those who were least concerned about the fiscal health of VA medical care still said opportunities for continuing education and travel funds for meetings were woefully inadequate, although others said the resources are made available through the facility's academic affiliation.

"The fiscal crisis is of major proportions," a Midwest chief of staff wrote. away entirely, both the range and the quality of service has diminished as funding has become limited.

"Some kinds of surgery are no longer being done, new diagnostic and therapeutic techniques are not being introduced widely, obsolete equipment is not replaced, deteriorating physical plants are not repaired, and almost all capital funds—equipment, construction, etc.—are used to support operating expenses."

Another Midwest facility's chief physician called the budget process a national disgrace because of approval delays that impair hospital planning.

"Numerous plans for improvement of delivery of care (needed nurse specialists, IV teams, improved escort services, adequate psychotherapy services, updated equipment) cannot be developed due to lack of funding or nebulous FTEE ceilings," he said.

A New England facility's chief of staff said few veterans in need of hospitalization have been turned away without a place in the community after a "determination of need for hospitalization," but there are signs of fiscal crisis, he maintained.

"Many of our scheduled clinics are backed up from two to six months. Hip and other joint replacements are delayed six to nine months because of lack of funds to pay for the prosthetic devices.... "

A Southern hospital's chief of staff said his staff was harried and fatigued from recruitment and retention problems due in part to funding shortages and in part due to unimaginative personnel policies.

At a West Coast hospital, the chief of staff said the capital base is being undermined. "You cannot continue to take productivity cuts year after year without eventually stripping away muscle as well as fat and eroding morale.

"Our needs for equipment and construction are becoming critical. At some point, there will have to be a 'catch-up' period. The same is true of federal salaries."

The fiscal crisis is reflected in a six-month waiting list for orthopedics, another Western hospital chief of staff said. A Midwestern facility's medical chief said he feels the pinch in an inability to order fee-basis care when needed.

"I have noticed new carpeting in the administrative suite when patient care facilities went wanting," a Midwestern chief of staff said. Yet another medical chief in a neighboring state observed, "Construction funds are separate from medical care. We have to keep up our properties, but people do not understand these mechanisms."

At a Northeastern hospital, the chief of staff said physician turnover is a good yardstick of resource needs, acknowledging his facility has imposed stricter medical need criteria for admission, has sicker patients, and a shortage of psychiatrists.

"The staffing shortages are worst in psychiatric care areas," a mid-Atlantic chief of staff agreed, "which is ironic since the VA provides 50 per cent of all the inpatient psychiatric care received by veterans in the U.S., a higher percentage than for medicine and surgery."

In general, he added, "Current staffing levels in VA facilities are below comparable university hospitals and below most public sector hospitals."

As did several of his colleagues in the South, one chief of staff voiced frustration about variance of access between geographic areas. "Many eligible veterans including service-connected are turned away in Region 3, (a) rationing of care," he said.

"The resources are probably at least $400 million short for the system to maintain current services," he said.

(NEXT: Resource Allocation Methodology)

(Second in a series)

By Terry Jemison

WASHINGTON—Concern about waning medical budgets at some Veterans Administration hospitals has grown serious enough to prompt oversight hearings in Congress this month.

Some physicians are preparing to use the hearings to focus part of the blame on VA's "resource allocation methodology," or RAM model, which determines how the federal budget sum for VA medical care will be divvied up among veterans hospitals. Panels of both the House and Senate veterans affairs committees are expected to examine the hospitals' budget situation in separate hearings.

One prospective witness said he will tell Congress the RAM is a failure encouraging "sicker and quicker discharge of veterans...and the creation of a reference for admitting, treating, and discharging patients that replaces the only valid reference, namely, 'what is best for the patient?'"

Another VA field official said the RAM formula has been manipulated repeatedly to protect "flagship" VA hospitals while making geriatric and psychiatric care more difficult in the rest of the system. Some believe tertiary care is penalized because of the absence of a severity illness, and numerous chiefs of staff at various VA hospitals appear to share frustration that there is little return for productivity as the overall pool of inflation-adjusted money appears to dwindle.

Peppered with acronyms like WWU, RUG, DRG, and LOS—along with statistical concepts like trim points—the RAM itself did not lend itself to much congressional attention as its controversial formula for slicing the budget pie evolved in the last few years. Groups such as the National Association of VA Physicians (NAVAP) have been disappointed that veterans service organizations, like Congress, have been relatively silent on the effects of the RAM on patient care.

"These times cry for aggressive and effective leadership and management," NAVAP executive director Dr. Paul W. Schafer said. "Instead, we have DRG (diagnosis-related group) RAM, a completely predictable failure—what would seem to be an unfulfilled agency death wish which now appears to be in its last agonal convulsions."

Many VA officials support the RAM concept or its results as an improvement over the historical-cost system on which budgets previously were based. For each dollar "lost" by a northeast psychiatric hospital, for example, there is a "gainer" hospital somewhere, probably in the Sunbelt, where officials previously complained the old budget system was not keeping up with the growth of demand.

Further, the General Accounting Office, in a report published last year, found that while the RAM evolved amid problems with questionable data and field concerns that the burdens of care for psychiatric and AIDS patients were not treated validly, it still is a significant improvement over its predecessor methodology.

The GAO relied on VA documentation and testimonial evidence on RAM's intended operation, but the congressional agency did not validate the extent to which RAM accurately measures workload as VA intends or actually performs as expected. Conceptually, GAO applauded VA's efforts at "matching costs with outputs."

"The methodology should heighten the sensitivity of field managers and direct service providers to the appropriateness of the services and the cost of providing care," GAO concluded.

However, less than a year later, a survey of chiefs of staff at VA hospitals around the country indicated that much of the dissatisfaction with the RAM is in its administrative burden and influence on hospital directors to press for the production of weighted work-units (an increment of workload measure), a burden some liken to an army of "green eyeshades" employed by directors to "outfox the foxes," as one chief of staff put it, to ensure their hospital gets maximum return.

At a Northwest hospital, the chief of staff complained that the RAM rules are changed in Washington on a whim. "It is gamed to death," he wrote, "taxed to death and *will* be the death of tertiary medical care in the VA."

The pressure to turn out weighted work units has not only driven trends applauded by VA officials, such as increasing emphasis on outpatient care, but it also has led to what some consider an extraordinary amount of attention to "gaming" the system.

"The driving emotional force in all of this charade," Dr. Schafer of NAVAP said, "is the sense of guilt created in the players, those who bore the stigmata of not having done their best, particularly in those who were actual WWU-over-dollar losers.

"This DRG-RAM management disaster has now been in place just long enough, finally, to be recognized for the damage it has caused, not the least reason being the precious scarce funds for patient care which facility directors, regions, and Central Office have diverted to DRG-RAM administration...."

The cost of "DRG-RAM gamesmanship," he said, is measured in decremental funding for supplies and equipment, fewer operating hospital beds, delays for patients, and less ambulatory, intermediate and nursing home care.

A *U.S. Medicine* survey of chiefs of staff around the country found such views were not uncommon, but far from unanimous.

"The problem," one Southern chief of staff said, "is that the dollars to support this increased revenue (from increased workload) are not available, and the revenue reward is then decreased by realigning the weighted work units to match the dollars."

A Region 5 chief of staff was more succinct: "The RAM is truly an Alice in Wonderland methodology, an unverifiable nightmare creating utter chaos in the field."

A Midwest facility reported that RAM started off well, improving efficiency, but has degenerated into "a disaster," with the chief of staff there observing, "A mechanism for addressing the problems of facilities harmed by RAM methodology is wholly inadequate if not nonexistent."

"It is a zero-based system where inadequate total dollars are redistributed among VA hospitals," a region 6 medical staff chief said.

Another region 6 chief of staff at a Northwest hospital went even further. "The RAM is a joke. It is poorly thought out, changed on a whim, has so many adjustments to try and fix its shortcomings that it is unintelligible."

Others had a different view, such as a third Region 6 medical chief, who said it is an improvement over the historical cost system, though its main drawback is the cap, or limit, on the flow of resources between medical centers.

"RAM would be okay if done properly," a mid-Atlantic chief of staff said, "but cuts are made by RAM plus withdrawals by Central Office for other reasons.... RAM does not consider severity of illness, so tertiary hospitals are at a disadvantage."

Additional mixed feelings were shared by a Southern hospital in Region 3, where the chief of staff said it is superior in equity to the old system, but it is significantly underfunded, and while it redistributes money from large hospitals, "it is somewhat blind to small, very active hospitals."

The Region 3 chief of staff at another Southern hospital wrote, "RAM is a decided improvement over the old self-serving system, but it is only an intermediate step to the fiscal solution of independent patient billing based on cost. The RAM task force should now concentrate their efforts on a capitation method of resource distribution."

The old system basically was comprised of "head counts," a Midwest chief of staff said.

"The RAM is an improvement," a Western chief of staff said, "primarily in the fact that it is forcing all participants to address proper use of funds and to show results, i.e. workload."

A Southern hospital official said RAM is an improvement, "but was put into place without adequate testing...(and) is severely underfunded, leading to cutthroat competition and gaming."

A Midwest chief of staff had similarly mixed reactions. "RAM appears a viable and logical system of funding," he said. "The 'formula' is totally ridiculous, however, in that with all the tampering and adjusting, the entire methodology becomes a sham without logic or fairness. The old cost system was better by comparison."

"Resource allocation is a joke," another Midwest chief of staff said. "Hospital staff who work hard and efficiently are not rewarded for their effort. A cap is placed on their profits, thereby making it impossible to hire more people."

"The RAM is unrealistic for much of the chronic illness, rehabilitative programs and psychiatric problems confronting the veteran population," a mid-Atlantic hospital chief of staff said.

He maintained the DRG system (in which RAM shares a basis) was developed for patients in small community hospitals for whom family backup and care is more readily available on discharge.

A Western chief of staff in Region 7 agreed. "With the various legally mandated care for certain patient categories, the DRG is not suited for VA use. Shrewd maneuvering and gaming are necessary to survive."

A mid-Atlantic chief of staff observed that quality of care is suffering under RAM. "Many medical centers are seeing more patients and doing more for them, yet finding they are still losing in ensuing budgets as the dollar generated per weighted work unit decreases....

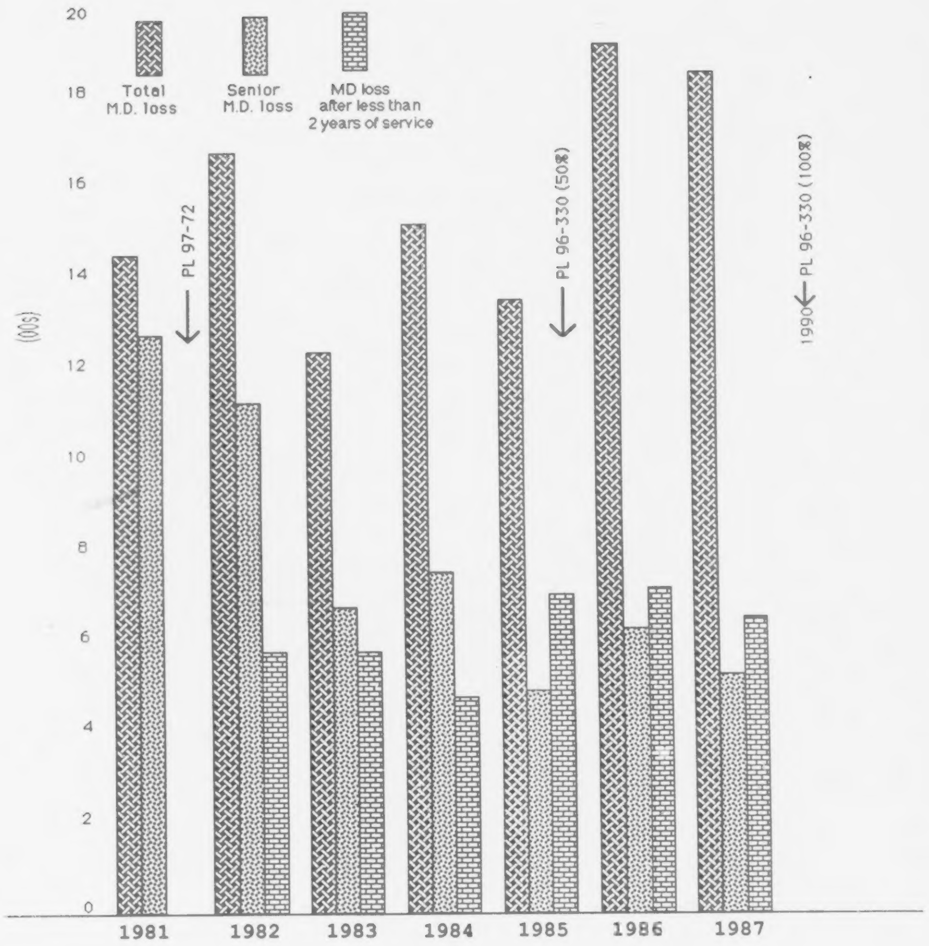
"Large metropolitan medical centers appear to have more longer-term placement problems and greater difficulty competing for nurses, health care professionals and clerical staffs, hence higher salaries (special rates) which aren't adequately compensated for in the RAM model."

"The game has gotten to the point where subversion of the system to become a winner has become more important than patient care," a Northeastern chief of staff said.

A Midwestern chief of staff agreed. "Much effort is expended in adapting behavior to maximize RAM reimbursement; when the RAM drives efficiency and good care, this is fine, but where time is wasted on RAM analysis rather than efficiency *per se*, scarce resources are wasted and the focus is backwards."

While RAM is an improvement over the historical method, a Midwest chief of staff said, the two-year lag between workload and reimbursement "severely penalizes growing medical centers and rewards those that are shrinking."

However, a Northeastern facility's chief of staff said the historical cost system was better. "The RAM benefits large/complex VAMCs. The small, rural VAMCs are negatively impacted by the new grouping refinement under the RAM."



VA PHYSICIANS

WHO HAVE LEFT THE SYSTEM

Alex M. Raney, M. D., F. A. C. S.
1601 Kirkwood Highway - Wilmington, Delaware 19805
Telephone: 994-2511
654-2244

August 29, 1988

Paul W. Schafer, M.D., Executive Director
NAVAP National Headquarters
3400 International Drive, N.W.
Pod K-2
Washington, D.C. 20008-3098

Dear Paul:

I am writing to you as a liasion officer from the VA Medical and Regional Office Center in Wilmington, Delaware on behalf of our remaining physicians who are responsible for the delivery of health care to the veteran patients and who teach and supervise the educational activities of the residents and medical students, and as a chief of urology at this hospital, as well as a professor of urology and chairman of the residency review board at Thomas Jefferson University. At this time, we seek your and our national organization's assistance in whatever suitable way that you may think is feasible.

The enclosed memorandum is self-explanatory and does not need further clarification of the crisis at this VA center and perhaps at those across the country. The fact is that this VA hospital is the only one in Delaware, and due to geographical boundaries, draws its patients not only from the entire state of Delaware, but also from the surrounding states of Maryland, Pennsylvania, and New Jersey. The crisis that has been created at this very active hospital is based on two major factors which are:

1. Salary which is noncompetitive with the private sector
2. Severe and unrealistic budgetary cuts and FTEE cuts (approximately 15%) imposed by Central Office for this particular hospital, which already had manpower problems

To elaborate, the transformation that has been taking place in this hospital during the past six months includes the following:

1. The chief of nuclear medicine and all of his staff have left for better pay in the private sector, and the service has shut down completely.
2. The chief of cardiology left for private practice.
3. The chief of ENT left for twice as much salary in the private sector, and that service is in the process of being shut down.
4. The chief of nursing education resigned.
5. A full-time orthopedic surgeon left, and the entire orthopedic service is slated to be closed.
6. The chief of surgery just resigned this month to go into private practice.
7. The maxillofacial and podiatry services are being phased out arbitrarily.
8. The loss of nurses and technicians to the private sector for better pay has rendered our laboratory, x-ray, and nursing services at a submarginal level.

And finally, those competent and hard-working employees who are looking for better opportunities and jobs in the private sector are incalcuable and beyond the description of this communication.

As the enclosed memorandum, which is filed with the dean of the medical school, stated so clearly, if the situation does not change by October 1988, the residency program at this hospital may be terminated. In my opinion, it is obvious that without resident house staff, this teaching hospital could not survive. This message only signals the beginning of the end for this active VA center in this state and perhaps for the rest of the country as well. It is ironic to think that in this election year, all the presidential candidates hug and embrace our veterans, but no one addresses their health care in the various VA hospitals around the country!

In conclusion, we would like to appeal to you to do everything in your power to accomplish the following objectives immediately:

1. Increase the FTEE at this hospital to a realistic level, in order not to further jeopardize patient care
2. Supplement the current budget to allow for the purchase of additional medical equipment
3. Increase the salary of physicians and paramedical personnel to make it comprable with the private sector in order to keep this as well as other hospitals open.

Any assistance that you might render would be greatly appreciated by all of our physicians.

Respectfully yours,

a m Raney MD

ALEX M. RANEY, M.D.

received
9/6/88

HINES
VAMC

Veterans
Administration

Memorandum

COPY

Date August 18, 1988

From Chief, Medical Service (111)

Subj Status of Equipment August 12, 1988

To Director (00)
THRU: Chief of Staff (11)

This memo will present brief statements with appendices for detail.

1. Dialysis machines. We use 25 machines, 20 being outdated. While the old ones are usable, modern short-time dialysis can't be given because sophisticated controls are lacking. The old machines do not permit the ready adjustment of solutions for optimal treatment. New machines would lead to reduction in staff. See Appendices A 1,2.

2. GI endoscopy. Inadequate equipment leads to less than optimal diagnosis and treatment, delays work-up and impairs cancer case finding. Details in Appendix B.

3. Cardiology today is highly dependent on equipment. We do 200 heart operations per year and have done 20 transplants. We have an up-to-date catheterization laboratory but our EKG technology, our treadmill and Holter testing are all done on badly outmoded, inefficient equipment. We may have had an avoidable death because both aortic balloon pumps were broken down. We frequently run out of proper instruments for angioplasty. Details in Appendix C.

4. Respiratory equipment is largely obsolete. This is of concern not so much because of frequent repair costs but because the quality of life support is less flexible, less safe, lacks monitor capability and does not facilitate weaning.

5. Pagers. Our expanding medical school affiliation constantly increases the percentage of part-time physicians, all of whom need pagers. We are short.

ARMAND LITTMAN, M.D.

Attachments

APPENDIX A 1

Veterans Administration

Memorandum

Date August 12, 1988

From Chief, Nephrology Section (111L)

Subj Dialysis Equipment

To Chief, Medical Service (111)

1. At the present time we have 5 modern dialysis machines and 20 outdated machines (mostly Gambro AK-10).

2. The Gambro AK-10 machines are of limited suitability for the following reasons:

a. The outdated AK-10 machines do not have volumetric control of the fluid removal rate; fluid removal rate is adjusted by manually estimating the dialyzer resistance to fluid transfer and by adjusting the blood and dialysate pressures manually. Lack of a volumetric fluid removal controller is the most important cause for dialysis hypotension.

b. The outdated AK-10 machines are not adaptable to the rapid blood flows and use of bicarbonate dialysis solution required for high efficiency, short treatment time dialysis. Bicarbonate dialysis solution is required for all unstable patients and for all patients undergoing short treatment dialysis. Wider use of short treatment dialysis is of benefit to patients, increasing treatment palatability and shortening the total time that dialysis personnel need to be in attendance. Should more of the modern machines be made available, the number of dialysis personnel required for the unit can be reduced accordingly, resulting in substantial monetary savings.

c. The dialysis solution sodium level cannot be easily adjusted between patients on the old AK-10 machines. Different patients often require different dialysis solution sodium levels to be dialyzed efficiently and safely.

d. It is impossible to alter the amount of acetate or bicarbonate in the dialysis solution with the old AK-10 machines; thus it is difficult to achieve optimum acid-base control with these machines.

3. The old machines have been in use for 10 years; rules require 5 more years of service before routine replacement.

TODD S. ING, M.D.

VA FORM 2105

APPENDIX B

GASTROENTEROLOGY

1. Both of our flexible sigmoidoscopes have been beyond repair for two years and have not been replaced. This knocks out much of our in-house colon cancer screening and it abolishes the training of interns and residents at colon cancer case finding.

2. We have three colonoscopes. Two have not been repaired because the funds for repair have been exhausted. We have one new scope which functions well. Because this instrument is used full-time, it is in sterilization about one-third of the time after each use. The scheduling of colonoscopy is thus inefficient and we have a backlog of six or seven days for inpatients. This wastes money and delays the finding of cancer.

3. Video endoscopic equipment does not work, has no tape capability, and is archaic, beyond repair. This reduces the clinical utility of endoscopy because findings cannot be demonstrated to those who must make decisions, for example, surgeons and senior staff.

4. There are two gastroduodenal scopes and one adapted for ERCP (getting into the sphincter of Oddi for study of pancreas and biliary tree). There are no backup instruments, which are fragile.

5. Supply budget shortages require us to reuse needles for sclerotherapy (treat GI hemorrhage) and brushes for cytology. These are intended for one-time use, but re-use is better than none. At times gastrostomy tubes placed by gastroscopists have been brought in from private sources because our budget was exhausted. We at times lack sufficient Cidex, a sterilizing solution, for proper sterilization of endoscopes. Better sterilization would be achieved by an automatic sterilizing device that costs $2,000 and has been requested for several years.

6. To stop GI bleeding we use an obsolete cautery, which is not as safe as the new ("bipolar") device that costs $5,000.

COMMENT

We are "making do". We do so with some inefficiencies and with less than optimal practices.

Appendix C

Veterans
Administration

Memorandum

Date August 16, 1988

From Henry S. Loeb, M.D.
Program Director in Cardiology (111G)

Subj

To Armand Littman, M.D.
Chief, Medical Service (111)

1. Treadmill Testing - 30 to 40 treadmill tests per week are being done utilizing equipment 15 years old. Approximately ½ of these tests cannot be properly interpreted because the EKG recording equipment is incapable of eliminating motion artifact. A new up to date treadmill unit has been requested for several years, but has not been purchased. Failure to obtain readable treadmill examinations can result in both unnecessary and more expensive additional procedures (such as Thallium 201 imaging or cardiac catheterization) or equally important, may contribute to the omission of appropriate further evaluation in patients with early and treatable disease.

2. Ambulatory EKG Monitoring - Budgetary restrictions resulted in purchase of a low cost system not designed for high volume, hospital use. Lengthy delays in scheduling Holter examinations (only 2 or 3/day can be done), and frequent need to repeat the examinations because of equipment failure often leads to unnessary hospital admission or delay in hospital discharge. On occasion, inability to rapidly obtain and accurately scan repeated ambulatory EKG data has resulted in patients being referred for invasive electrophysiologic testing.

3. Intra-aortic Balloon Pumps - The need for intra-aortic balloon pumping has continued to increase commensurate with more aggressive management of unstable or high risk patients such as patients waiting for cardiac transplantation, patients undergoing emergency catheterization for acute myocardial infarction and patients undergoing scheduled high risk procedures such as repeat coronary bypass or complex coronary angioplasty. Nevertheless, the few balloon pumps available are old and frequently break down. This has resulted in cancelling of scheduled procedures, or the emergency borrowing of pumps from our affiliate University Hospital. On at least one occasion a patient died while attempts were being made to obtain a balloon pump from outside since there were no working pumps at Hines.

4. EKG - Electrocardiograms are still dealt with as they were 20 years ago in that hard copy tracings must be attached to the chart and a copy hand carried to the reader who makes a hand written report which is then mailed to the patient's ward or clinic. Old electrocardiograms are available only (but not always) by obtaining the prior hospital chart, since no independent filing system of EKG's is possible with the limited clerical staff available. Computerization of EKG interpretation, filing and retrieval is no longer considered new technology, and in fact V.A. was instrumental in development of EKG computerization. Funding for computerization of EKG service has not to date been made available to Hines or as contemplated several years ago, to include and link the other large V.A. Hospitals in the region.

5. Catheterization Laboratory Supplies - With over 1000 procedures performed in our catheterization laboratory last year our supply budget remains well below what would be required to do far less. Therefore, we are constantly out of necessary types of catheters, and are unable to stock and utilize newer types of catheters and wires, especially important for optimal results during coronary angioplasty. This has resulted in cancellation of some procedures and in using certain types of catheters not optimal for the specific circumstances which can result in inadequate films or unsuccessful angioplasty results with the patient ultimately needing heart surgery.

Henry S. Loeb, M.D.

Edward Hines, Jr.
Hospital

Hines IL 60141

Veterans
Administration

MEMORANDUM

In Reply Refer To:

To: Armand Littman, M.D., Ph.D.
Director, Medicine Service

Date: August 16, 1988

Subject: Status of Respiratory Equipment at the Hines VA Hospital

The deficient state of equipment in use by the Respiratory Disease Section is illustrated by some of the following examples.

1. Ventilators and Other Respiratory Therapy Equipment

A number of ventilators are in use throughout the hospital. The standard model is the Puritan Bennett Model MA-1 of which approximately 19 are in service. This machine was a state-of-the-art device during the 1970's but has been replaced by a newer generation of machines such as the Servo 900C. These provide many options not available to an earlier generation of physicians. Major advances in "weaning" techniques - approaches to helping the convalescent patient gain back enough strength to become independent of the ventilator - are not available on the older machines. Nor do the older machines offer the newer more flexible modes of ventilating the critically ill patient. After 10 years of use these machines are clearly obsolete. Maintenance costs are considerably higher than for the newer generation of devices which employ solid state logic circuitry.

Of greater concern is that patient safety is jeopardized with the use of older equipment from which many patients cannot re-establish independent breathing. It is generally recognized that the longer a patient requires the support of a ventilator, the more likely he or she is to develop a fatal complication related to the support systems, hence the compelling need for rapid resolution. Moreover, lack of monitoring modes on the older devices puts the critically ill patient further risk. None of the specialized equipment such as high-frequency or jet ventilators are available on a routine basis. Bedside monitoring devices such as on-line oximeters and parameter alarms have simply never been available to patients in critical care beds.

2. Diagnostic Pulmonary Equipment

Fewer than half a dozen portable oximeters are available for use within the hospital. These devices conveniently and non-invasively measure the oxygen content of a patient's blood, saving the need for frequent blood drawing.

One of several blood gas machines for monitoring the progress of patients with life threatening pulmonary disease has outlived its life expectancy and cannot be trusted to yield analytical results needed for basic clinical care.

3. Bronchoscopy Equipment

The procedure of bronchoscopy requires intermittent access to fluoroscopy (radiology) equipment for patient safety. This must be provided on site in a dedicated bronchoscopy suite so that patients not be moved during the procedure. An old C-arm fluoroscope is available but out of service more than half of the time.

Jason Kelley

JASON KELLEY, M.D.
Program Director
Pulmonary Disease

NATIONAL
FEDERATION
OF FEDERAL
EMPLOYEES

NFFE

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STATEMENT

BY

THE NATIONAL FEDERATION OF FEDERAL EMPLOYEES

BEFORE

THE SENATE COMMITTEE ON VETERANS' AFFAIRS

ON

PATIENT CARE AT VA MEDICAL FACILITIES

SEPTEMBER 9, 1988

Mr. Chairman and Committee Members:

On behalf of the National Federation of Federal Employees, which represents 14,000 employees of the Veterans Administration, most of whom work at VA hospitals and outpatient clinics, I appreciate the opportunity to appear before the Committee today and address the question of patient care.

The quality of the care received by the patients at VA hospitals is of paramount importance to our members, and they are concerned about the current level of care at their installations. As the veteran population ages, and as medical technology improves, the challenge of providing excellent care will inevitably increase, and our members fear that the challenge will not be met.

In order to prepare for this challenge, the VA must make a commitment now to hiring, training and retaining the best employees and then providing those employees with the best equipment and the best environment in which to care for the nation's veterans. A recommitment today to the agency's mission is essential. Without this recommitment and the dedication it will entail, the VA will cease to provide the kind of care the veterans have come to expect and deserve.

In previous appearances before this Committee, NFFE has stressed the serious problems the agency has in recruiting and retaining qualified health care personnel, particularly those involved with direct patient care. Sadly, we are unable to report that the situation has improved.

The high attrition and recruitment problems which the agency is currently experiencing stem from a series of crises. Proposed and actual budget cuts have severely reduced resources and damaged morale. Some of the staffing problems are certainly rooted in the VA's outdated and generally inequitable personnel system. The major differences in the way Title 38 and Title 5 employees are disciplined are only exacerbated by the lower pay and benefits VA health care personnel receive when compared to private-sector employees.

However, a pattern does seem to be developing around three areas: premium pay, overtime, and length of shifts. Of major concern to the Title 5 employees (Licensed Practical Nurses, Nursing Assistants and Graduate Nurses) is the premium pay issue. The Title 38 employees (Registered Nurses) receive special premium pay rates for weekend and evening duty which is not available to Title 5 employees. While it is understood that premium pay for Title 38 workers was introduced to improve recruitment and retention at VA installations, the disparate treatment has caused severe morale problems. Premium pay for an RN working the same shift as an LPN who receives no premium pay does not reflect enlightened management. We recommend that premium pay be made available to Title 5 health care personnel as well.

Another pay discrepancy that is hurting the workforce concerns the overtime rates for registered nurses assigned to different units of the same hospital. At the Northport, New York VA Medical Center, for example, the surgical unit nurses do not receive the same overtime differential as those assigned to other units. This phenomenon seems to vary from hospital to hospital, but its underlying justification seems to be that overtime hours worked by surgical nurses is only worth time and one-half, while overtime worked by nurses in the internal medicine or psychiatric units qualifies for time and one-half plus an additional 25%. Predictably, the attendant morale problems are serious, and could be easily solved. We recommend that VA Hospital Administrators be directed to offer uniform overtime rates to all nurses. We also recommend that the Committee seek to repeal the $20.00 per hour maximum overtime rate for nurses because it penalizes those with the most experience and time in grade for working overtime.

The overtime problems at VA medical installations often stem from insufficient staffing which is "solved" by assigning staff to lengthy rotations. In truth, if we looked for a single cause of VA's most serious problems, that cause would probably be insufficient staffing levels. Not enough health care personnel are hired to cover the units when employees are ill themselves. As a result, those already at the hospital are required to work overtime. The strain on personnel who must work a second shift after already working a 10 or 12 hour shift endangers patient care, and results itself in increased sick leave use.

NFFE members feel that if staffing levels were adequate to prevent frequent overtime assignments, health-care personnel could tolerate the longer shifts. Or, if shifts were shortened, employees would be able to handle the overtime requirements better. As the situations stands now, however, the combination of 12-hour shifts and frequent overtime is sapping the morale, dedication and even the health of VA employees. The burn-out rate for health care personnel then escalates, causes vacancies, and more overtime is assigned to staff the hospital.

This situation is more than just a morale problem. The consequences are instead far reaching. The VA hospital at Fargo North Dakota is a good example of a hospital system in decline. Fargo has lost seven registered nurses in the past two months. A surgical unit with approximately 25 beds was closed in July because there were not enough personnel to keep it open. There is a six month waiting list for nonemergency surgical procedures. Nurse anesthetists, who assist in the administration of anesthesia, have been assigned additional and essentially unrelated post-operative duties. The same hospital is forced to contract out the Chief Radiologist position and is currently working without an EKG Chief. The physician in charge of Gastro-Enterology left and has yet to be replaced. One does not need a crystal ball to see how potentially explosive this state of affairs is.

Unfortunately, Fargo is not unique. Nursing vacancies left unfilled, wards shut down for lack of staff, and physician slots permanently open reoccur in the dismal report from most of NFFE's VA installations. Part of the solution is certainly better pay and benefits. But another approach to halting this downward spiral is increased staffing levels and improved shift rotations. Many private-sector hospitals have found 8-hour shifts to be more efficient than 10-hour rotations, and certainly preferable to 12-hour shifts. We recommend that the VA Administrator be directed to explore the use of 8-hour shifts for health-care personnel.

In addition to staffing considerations, NFFE members are particularly concerned that the level of training they receive is often inadequate. In-service training, which refers to special, on-the-job training, our nurses tell us, is "a joke." Many nurses are unable to leave their units to attend the training because they are the only RN assigned for that shift. Those who do attend often find the training to be inadequate, yet they are assigned extra duties nonetheless. Staff already spread thin cannot cope effectively with additional duties for which they have been inadequately trained.

Many nurses worry privately about the possibility of malpractice suits if "something should happen" while they are assigned to cover patients who have conditions with which they are unfamiliar. In today's specialized fields of medicine it is not enough to assign "a nurse" to a unit. That individual must be trained for the unit's speciality. Anything less is a danger to the patient.

Licensed Practical Nurses, Graduate Nurses, Registered Nurses and Dental Assistants who choose to work for the VA often forego higher pay, attractive educational benefits, reduced prescription prices and even lost-cost eyewear available to employees at the private-sector hospitals in their area. Yet, NFFE's VA nurses contend that the rampant morale problems they are witnessing are more the result of poor management and inadequate staffing. Nurses who have been with the VA for 20 years report that they have never seen morale at such an ebb. "Everyone's trying to get out," is a phrase heard over and over. And the patients are the losers.

The VA health care system's first concern should be quality care for the veterans, and in that respect the agency is failing. When morale is ominously low, when turnover is rampant, when personnel are working 20 hours in a row, and veterans are turned away because there are no nurses to staff the empty beds, the system is failing. NFFE is confident that this Committee will be able to address these problems and work with the VA Administrator to find equitable solutions, and we look forward to working with the Committee towards that end.

This concludes my statement. I will be happy to answer any questions.

National Federation of Federal Employees

NFFE

James M. Peirce • President
Abraham Orlofsky • Secretary Treasurer

In reply refer to: ____________

September 30, 1988

The Honorable Alan Cranston
Chairman, Senate Veterans' Affairs Committee
414 Russell Senate Office Building
Washington, D.C. 20510

Dear Chairman Cranston:

When the National Federation of Federal Employees testified before your Committee on September 20, 1988 concerning patient care at Veterans Administration facilities, you asked that NFFE provide any additional information on conditions at VA facilities similar to those we described at Fargo, North Dakota. You also asked that NFFE provide our views on the Colorado Nurses decision and how that matter might be best resolved. I am happy to respond to both requests, and hope that the following will be useful to you. Any questions concerning this material may be addressed to NFFE Legislative Liaison Marie Winslow (862-4437).

CONDITIONS AT SELECTED VA FACILITIES

Nearly all of the VA employees who were interviewed for this summary were highly nervous about reprisals from their individual administrators if they were to become identified with unfavorable reports on their facilities. Inasmuch as the employee reports criticize staffing shortages, supply shortages, turnover and morale problems, rather than the shortcomings of individual administrators, we believe this widespread employee fear speaks volumes about the unacceptable management at some VA facilities.

Amarillo, Texas

There is a high level of turnover at the Amarillo VA facility, but they are able to replace those employees who leave.

The morale is poor, in part because nursing staff are aware that their bonus money was used to purchase supplies. Even so, there are not enough infusion pumps for those patients who need them, nor enough employees on the housekeeping and engineering staff to support the nursing staff.

1016 16th Street, NW; Washington, DC 20036; Phone: (202) 862-4400

NFFE National Vice Presidents:
Region 1, Georgiana Kachura, Huntington, NY
Region 2, Robert E. Estep, Jr., Chambersburg, PA
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Region 4, Richard Reiman, Terlton, OK
Region 5, William P. Davis, Parker, AZ
Region 6, Gene Needham, Port Hueneme, CA
Region 7, William Chasko, Missoula, MT
Region 8, Jan Lambert, Kansas City, MO
Region 9, Sheila Velazco, Muncie, IN

The Amarillo VA assigns nurses to three eight-hour shifts but finds it necessary to assign mandatory overtime or work shorthanded when employees use sick leave.

Amarillo had the fewest problems of any facility contacted by NFFE.

New Orleans

Beds have been shut down at the New Orleans facility ostensibly because of construction, but employees there say there were not enough nurses to staff the beds if they were kept open.

The turnover is high among nurses because of better pay rates in the private sector and better shift scheduling.

Many of the "Chief" medical positions are unfilled, and there is a four to five month waiting list for non-emergency surgery.

Simple, yet necessary supplies such as gauze and "Chucks," which are used to protect bed linen used by incontinent patients, are frequently unavailable.

There are numerous complaints about the professional competence of the physician assigned to the employee health care unit.

East Orange, New Jersey

Many nursing positions are unfilled because the pay and scheduling at private hospitals are superior to those available at the East Orange VA facility.

A recent reclassification resulted in 42 RNs being disqualified for special pay raises.

The hospital frequently runs short of linens because they receive only one shipment per week from the contractor.

San Francisco, California

There are nine unfilled openings for X-Ray technicians at the San Francisco VA facility, where bone cases are handled on Tuesdays. On a recent Tuesday, there were still eight patients lined up waiting to have their X-Rays taken at 5:00 p.m.

X-Ray technicians at private hospitals in the area make up to $8,000 more per year than VA technicians.

Morale is not poor, it is bad. People are trying to leave from almost every position.

Supplies have run very low in most departments.

The Medical Intensive Care Unit was combined with the Surgical Intensive Care Unit and patients have been turned over to other hospitals for lack of space.

Patients are frequently transferred from Intensive Care to the Respiratory Care Units and vice versa on the basis of bed availability, rather than medical need. Patients are also shifted from medical to surgical wards and vice versa because of bed shortages. It should be noted that separate training is necessary to care for the very different conditions of medical and surgical patients.

The employee turnover in the Intensive Care unit was 50% last year. Employees are leaving for higher pay and better working conditions.

During night shifts, one RN and one LPN can be responsible for as many as 30 patients. At the end of the fiscal quarter, the wards routinely run out of dressings and gauze. The X-Ray department is spending down their stock of barium and film. The hospital also runs out of linens each week before their contractor delivers new supplies.

Jackson, Mississippi

Three floors, totaling between 90 and 100 beds have been shut down because of nursing shortages.

Forty RNs left between January and March 1988, with more leaving every day.

Turnover is high, not just because of the pay rates, but also because of the working conditions. On a recent day, two RNs had to handle an outpatient clinic load of between 150 and 170 patients without any other assistance.

Most non-emergency surgery has been cancelled for lack of staff.

The surgical unit has run out of surgical supplies, and has had to borrow what they could from other wards.

The Ear, Nose and Throat Clinic has been waiting five years for certain equipment. Equipment shortages exist in other clinics as well.

Mandatory overtime is high because there is insufficient staff to cover employee sick leave. In some cases, the units are reduced to working short-staffed.

Morale is "extremely low."

Premium pay had been awarded to non-RN nursing staff for three weekends only before it was cancelled.

Supply service employees were upgraded to GS-6 to reflect added responsibilities, but management has announced intentions to downgrade the employees to GS-5 without reducing duties.

Performance awards are affected by favoritism.

Employees feel that any complaint to the administration will result in retribution.

The constant turnover and ward closings result in training needs for the staff that are left unmet.

Miami, Florida

Approximately 250 nurses have left since January. One RN often has charge of as many as 30 patients. The facility has closed one bed in each of 200 rooms for lack of staff. Morale is "bad." Supplies, such as catheters, catheter bags, and chucks often run low. The hospital only recently acquired enough linen and pajamas to meet its needs.

Shreveport, Louisiana

The Shreveport facility is short 24 RNs out of the 175 it needs.

The full-time-equivalency ratings have been altered in an attempt to show increased staffing. This has been accomplished by reducing the number of nurses needed to adequately care for patients.

One RN and one nursing assistant often care for as many as 35 patients.

Approximately 108 beds have been closed for lack of nursing staff.

Nurses are given as little as 15 minutes training on special equipment before being assigned to care for a new patient who is on the equipment.

Much of the equipment is antiquated. Many of the older, rolling intravenous poles won't move, and there are no spare parts to repair them.

The waiting list for non-emergency surgery is months long.

Supplies are short, and doctors are forced to write alternate prescriptions when the first-choice medication is unavailable.

The facility is running low on linens and pajamas.

Morale is poor.

Employees are trying to leave, some of them switching to part-time so that they can interview for new jobs.

RNs are forced to come in and see the employee health care unit physician when they call in for sick leave. A nurse with a 104 fever related to a kidney ailment was ordered to see the employee physician where she was given a pelvic exam, which is not standard diagnostic procedure for kidney problems.

COLORADO NURSES DECISION

On July 19, 1988, the U.S. Court of Appeals for the District of Columbia Circuit ruled that the Veterans Administration is not required to bargain with employee representatives over working conditions of Department of Medicine and Surgery Employees. The Court stated, "In enacting section 4108, [of Title 38] Congress intended to give the Administrator unfettered discretion to issue regulations concerning the working conditions of DM & S employees.

This decision follows on the heels of more than twenty years of bargaining between labor organizations reprsenting Title 38 employees and VA over proposals ranging from safety and health issues to training and career development for such employees. We know of no situation in which the VA's mission of providing medical services was hampered simply because employee representatives were bargaining with management over conditions of employment.

Moreover, collective bargaining over such working conditions has enhanced VA's ability to attract and retain professional employees, which is critical especially during this severe nursing shortage. Pay levels for VA professionals are often lower than those offered at private hospitals In addition to which, VA nurses and doctors must now expect to undergo the indignity of random drug testing. These two factors, combined with the evidence of degenerating working conditions listed above, should compel the VA to recognize the vital importance of negotiating with its employees if it intends to retain them.

NFFE recommends that Congress swiftly enact legislation requiring the Veterans Administration to negotiate with its Title 38 employees over all working conditions as well as grievance procedures. Collective bargaining for professional employees is quite common in hospitals across the country, and VA would be doing a disservice to the nation's veterans if its fails to attempt to match conditions found in competing health care facilities.

I wish to thank you again for allowing NFFE to present its views to the Committee, and look forward to working with your staff to solve the problems currently facing the Veterans Administration.

Sincerely,

Beth Moten
for James M. Peirce
President

United States Senate

WASHINGTON, D.C. 20510

October 11, 1988

Honorable Ronald Reagan
The White House
Washington, D.C. 20500

Dear Mr. President,

We are writing to call your attention to the urgent funding problems now being experienced within the Veterans' Administration health-care program and to urge that you direct the Office of Management and Budget to send forth the supplemental request which was forwarded there. According to the Administrator of Veterans' Affairs, he has met personally with the OMB Director "to bring him up to date on the needs of the Medical Care account in FY 1989".

On September 9 and 20, the Senate Veterans' Affairs Committee held oversight hearings to explore various concerns which had been raised by VA doctors, nurses, and other health-care professionals, as well as affiliated medical schools, that the agency was not fulfilling its responsibility to provide prompt and effective health care to those veterans eligible for it. These concerns were validated at the hearing by 9 VA field witnesses who, testifying under oath, all described the current fiscal state of affairs as a "crisis" and "the worst financial crunch" they had ever seen in VA health care.

In connection with those hearings, the VA's Chief Medical Director has advised that the VA is facing at least a $635 million deficit for fiscal year 1989. Additionally, over the years, the agency has been reallocating large amounts of money from both recurring items -- such as inventories, drugs, and prostheses -- and non-recurring items -- such as equipment and maintenance and repairs -- in order to maintain daily operations. The cumulative effect of these reallocations is to reduce the current funding base by another $440 million, thus making the total VA health-care deficit approximately $1.1 billion in all.

On September 9, the Administrator testified that a supplemental request had been forwarded to OMB to assist in offsetting the anticipated deficit. The Administrator said he would do everything within his power, including appealing to you if necessary, to obtain timely Administration action on the request. On September 13, 1988, Senator Cranston wrote the Administrator to emphasize "two vitally important matters .... First, that the amount ... in such a request be sufficient to enable the VA in FY 1989 to maintain its current levels of services and comply with all applicable laws; and, second, that your actions be most expeditious in order to produce an Administration request that can be considered by the House Appropriations Committee when it marks up an FY 1989 continuing resolution.... I would underscore the testimony of the Chief Medical Director ... that an additional appropriation of $608 million [later revised upward to $635 million] is necessary for this purpose. Otherwise, depending on the amount of the shortfall, the VA would be forced to take a number of actions ... to cut back on health-care services to veterans."

On October 1, because no supplemental appropriation was received by Congress, the VA, as predicted, began cutting back on health-care services and veterans are now being turned away from VA medical facilities. Yet a supplemental request has not been forthcoming from OMB. We believe that this is tragic. Many of these veterans have nowhere else to turn for health care. The result of these cutbacks will be that the health and quality of life of a number of these veterans will deteriorate -- with fatal consequences in some cases.

We are especially concerned that OMB will be unsympathetic to the VA's supplemental request. In a May 24, 1988, letter to the Chairman of the House Appropriations Subcommittee on HUD-Independent Agencies, in connection with its consideration of the FY 1989 VA appropriation, OMB Director Miller stated that veterans' programs, among other items, are "a low-priority service".

Mr. President, we have been unable to determine whether or not the Administrator has sought your assistance. We wanted to be sure that you were personally aware of this very grave situation. We believe that the VA has an urgent need for additional funds in order to maintain the level of health-care services it offered in FY 1988. We respectfully ask that you personally intervene and instruct OMB to transmit the supplemental request to Congress immediately -- in adequate time for us to act prior to adjournment.

Your immediate attention to this matter would be greatly appreciated.

With warm regards,

Cordially,

Alan Cranston
John Melcher
Dennis DeConcini

Max Baucus
Brock Adams
John D. Rockefeller IV

cc: Honorable Joseph R. Wright
Honorable Thomas K. Turnage
Honorable William Proxmire
Honorable Jake Garn
Honorable Edward P. Boland
Honorable Bill Green

Howard M. Metzenbaum
Thomas Daschle
Quentin N. Burdick

Spark M. Matsunaga
George J. Mitchell
Alan J. Dixon

Patrick Leahy
Bob Graham
Daniel K. Inouye

Kent Conrad
Donald W. Riegle
Frank R. Lautenberg

Claiborne Pell
Daniel P. Moynihan
Terry Sanford

Wendell Ford
Jeff Bingaman
Tom Harkin

Carl Levin

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON D.C. 20503

NOV 4 1988

Honorable Alan Cranston
United States Senate
Washington, D.C. 20510

Dear Senator Cranston:

This is in response to your October 11, 1988 letter to the President concerning a supplemental appropriation for fiscal year 1989 for the medical care program of the Veterans Administration (VA).

A rigorous analysis and review of the need for supplemental funding in fiscal year 1989 for the VA health care system is being conducted in the course of preparing the President's fiscal year 1990 Budget request to the Congress. We appreciate receiving your views on this issue, and they will be carefully considered during this review.

Sincerely,

Joseph R. Wright, Jr.
Acting Director

IDENTICAL LETTER SENT TO:

Honorable John Melcer
Honorable Dennis DeConcini
Honorable Max Baucus
Honorable Brock Adams
Honorable John D. Rockefeller IV
Honorable Howard M. Metzenbaum
Honorable Thomas Daschle
Honorable Quentin N. Burdick
Honorable Spark M. Matsunaga
Honorable George J. Mitchell
Honorable Alan J. Dixon
Honorable Patrick Leahy
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Honorable Daniel K. Inouye
Honorable Kent Conrad
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Honorable Frank R. Lautenberg
Honorable Claiborne Pell
Honorable Daniel P. Moynihan
Honorable Terry Sanford
Honorable Wendell Ford
Honorable Jeff Bingaman
Honorable Tom Harkin
Honorable Carl Levin

TESTIMONY OF

SENATOR MAX BAUCUS

SEPTEMBER 9, 1988

SENATE COMMITTEE ON VETERANS' AFFAIRS

Mr. Chairman, I appreciate having the opportunity to submit testimony to your Committee on behalf of the veterans of the state of Montana.

I know that today's hearing is about the financial condition of the hospitals in the V.A. system, and that there is trouble throughout the system.

But I would like to discuss just one hospital, a very important one: the V.A. Medical Center in Miles City, Montana.

For as long as I have been in the Senate there has been a threat of some kind or other aimed at the V.A. Medical Center in Miles City, Montana. Someone is always trying to close it down.

It's vulnerable because it's the smallest hospital in the V.A. system.

But for the veterans who live in Eastern Montana, it's the only show in town.

When they need hospital care, they go to the Miles City V.A. Medical Center in Eastern Montana.

It makes sense.

It saves the V.A. money. It saves veterans and their families money. And they get quality health care in a facility they know and trust.

When I met with Tom Turnage two years ago, before he became the V.A. Administrator, I told him about Montana.

I tried to help him to visualize the big, open spaces. I wanted him to understand what distances are like.

Because if the Miles City Medical Center closes down, it's going to mean a lot of travelling for veterans who need health care. Many of them can't afford the cost of care, much less an added cost for travel and lodging.

I would like to share with the Committee some facts about Montana and the 108,000 veterans there.

Montana is a big state. It has an area of nearly 150,000 square miles, roughly equivalent to the area of the entire Northeast United States. But there are only two V.A. medical centers in Montana.

The Miles City V.A. Medical Center serves an area of 77,000 square miles, including 23 counties in Montana, 5 in North Dakota, and 3 in Wyoming.

Over 40,000 veterans live in the service area, and more than 25 percent are over 65 years old.

It has been said that eastern Montana's veterans could get health care elsewhere, at Fort Harrison or Salt Lake City. But it just isn't that simple.

It's 350 miles from Miles City to Montana's other V.A. medical center at Fort Harrison. That's about the same distance as Los Angeles to Sacramento.

But between L.A. and Sacramento, there are nine V.A. hospitals.

Mr. Chairman, Salt Lake City is exactly as far from Miles City as it is from Los Angeles -- 712 miles. That's a long way.

And believe me, planes don't leave very often from Miles City to anywhere.

Serving Montana's veterans is a formidable task. But Miles City has met the challenge. For a few examples:

-- The Miles City Medical Center has the lowest inpatient cost per weighted work unit of any V.A. medical center in the country -- about $31. Simply put, they get more bang for their buck. Most of the other small V.A. hospitals are in the $40-50 range.

-- Last year the American Legion and Disabled American Veterans established a volunteer-staffed transportation system using donated vans -- significant when you look at the numbers of veterans now being served at Miles City.

-- The Miles City Medical Center staff, together with Montana's veterans organizations, have been making outreach efforts to make sure that veterans who need care get it. One example is the increased use by Native American veterans.

But the V.A. here in Washington hasn't been doing much to help.

Three years ago, the V.A. proposed a "mission change" for Miles City that would have turned the facility into a nursing home and transfer point for sick veterans to larger V.A. hospitals like Salt Lake City and Denver.

The GAO looked into the mission change and found that the VA's justification for it was flawed and that the change was not in the best interests of the veterans in the area.

Since the GAO report, the mission change was put on hold.

Whether it will be revived again is unclear. No one is saying.

Now another battle is being fought -- that of cost containment directives that Miles City and Fort Harrison must meet, even after paring every corner and living off the shelf. The facts are:

-- Both the V.A. facilities in Montana are operating in the red right now.

-- The Miles City V.A. Medical Center has projected that its FY89 budget can sustain only a 58 percent occupancy rate. The center's average occupancy rate grew from 52 percent in FY86 to 63 percent last year.

-- The first nine months of the current fiscal year saw another significant increase in patient care: inpatients treated increased from 1,736 to 2,267; outpatient visits grew from 15,227 to 18,552.

-- The number of staff at the Miles City V.A. Medical Center has actually declined since 1983, in spite of the fact that the number of patients served has grown by 30 percent during that time.

So we have more patients being served than ever before with fewer resources at the Miles City Medical Center with which to serve them.

Mr. Chairman, we all recognize that cost containment is necessary. But rural veterans in Montana cannot be expected to bear so much of the burden of balancing the V.A. budget.

Rural health care is an important issue for my state. Maintaining access to quality care is always a struggle in rural areas. It's no less true for veterans' health care.

We have to start caring more about the people who are at the receiving end of cost-cutting policies. That includes the veterans of Montana.

The Miles City Medical Center has proven it can provide quality service to Montana's veterans -- in fact, innovative and cost-effective service. That should be encouraged, not stamped out.

With good reason, we have made a national commitment to the well-being of our veterans. That doesn't mean just the veterans who live in big cities. That means all veterans.

I hope that the V.A. will not try to revive the Miles City mission change. If it does, it had better do its homework next time.

The veterans of Montana have made it clear that they want and depend on the Miles City facility. I won't let them down in their fight to keep it.

Thank you, Mr. Chairman, and members of the Committee.

STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Adequacy of VA Resources to Meet Patient Health-Care Needs

Presented by

Harry N. Beaty, M.D.
Dean, Northwestern University Medical School
Chicago, Illinois

Senate Veterans' Affairs Committee
Friday, September 9, 1988

aamc

Association of American Medical Colleges / One Dupont Circle, N.W. / Washington, D.C. 20036 / (202) 828-0525

Mr. Chairman and members of the Committee, I am Dr. Harry Beaty, Dean Northwestern University Medical School. I am pleased to have the opportunity to share with you my concerns about the adequacy of Veterans' Administration resources to meet current and future needs of patients within the VA health-care system. My perspective is based on long experience with that system; first as a medical resident, subsequently as a consultant and educator in the clinical setting, and most recently as chairman of the Dean's Committee of the Veterans' Administration Lakeside Medical Center in Chicago. The relationship with this Medical Center is critically important to Northwestern University Medical School as it addresses its missions of medical education, patient care, and research.

I am appearing here today on behalf of the Association of American Medical Colleges. The AAMC serves as the national voice for 127 accredited medical schools and their students, 85 academic and professional societies, and 435 major teaching hospitals, including over 70 VA medical centers. There are strong ties between AAMC-member institutions and the VA. Currently, affiliation agreements exist at over 100 of the VA's 172 medical centers.

Any expression of concern by a member of the academic medical community about the adequacy of resources available to the VA's Department of Medicine and Surgery should be predicated on the recognition that the nation's medical schools and the Veterans' Administration have had a long-standing, mutually beneficial relationship. This relationship must be preserved. Together, we have improved the quality of care provided to eligible veterans. We have collaborated to educate future generations of physicians and other health-care workers and pushed back the frontiers of knowledge about the life sciences through VA-sponsored research. The latter is not an issue for discussion today, but one should never lose sight of the major research contribution to the VA's Department of Medicine and Surgery.

While the specifics of concerns that I will share with you shortly are derived from my experience at the VA Lakeside Medical Center, they are not unique to that setting. I have talked with several deans across the country, some of whom represent flag ship hospitals of the Veterans' Administration. The message is almost invariably the same: our VA hospitals suffer from a lack of the resources necessary to provide reasonable quality of care to patients. Keep in mind, I am not talking about what might be considered by some as the usual cry from the academic community that the VA does not provide enough support for education and research. This issue is patient care. This is important because we care about our nation's veterans and because we cannot educate future health-care professionals in a setting where the quality of care may be trending toward marginal.

Now I would like to discuss some specifics. At VA Lakeside, there has been a long-standing problem caused by inadequate ambulatory care facilities. Dedicated staff currently provide care for more than 150,000 outpatient visits a year in less than 25,000 square feet of space that was constructed for that purpose.

This is an increase of approximately 40,000 visits over the number seen three years ago. Recently, space that was intended for other purposes was appropriated for expansion of outpatient functions. This space is inefficient and dependent upon woefully inadequate elevators to accommodate an additional patient load. Ambulatory surgery facilities cannot begin to meet the needs of our patients, which can lead to hospital admissions that are inconvenient to patients and costly to the hospital. It should not be surprising to learn that patients may have to wait as long as 6 months for certain types of elective outpatient care. All of this occurs at a time when providers of care in the private sector are streamlining facilities and procedures in order to provide high quality, timely care to an increasing number of patients who can be treated in the outpatient setting.

There have been plans for a new outpatient facility at the Lakeside Medical Center for years, but implementation has been delayed repeatedly and recently has been put on indefinite hold. At the same time, a satellite outpatient facility was built at Crown Point, Indiana, 30 miles away. This facility is the responsibility of VALMC. To provide a point of reference for my previous testimony about the overcrowding in the ambulatory care facilities at Lakeside, the Crown Point clinic has 40,000 square feet of space for an anticipated maximum work load of 42,500 visits a year.

The satellite was opened in June, 1988, and will serve a group of eligible veterans who previously had difficulty receiving care in the VA system. Unfortunately, adequate funds for staffing, operation, and administrative support were not provided. Thus, money and staff were diverted from the operating budget of Lakeside. This has had a detrimental effect on both its inpatient and outpatient programs.

Of equal importance, it has produced frustration and stress in dedicated members of the professional staff/faculty. This led to the resignation a few months ago of the Associate Chief of Staff for Ambulatory Care. He has moved to a similar position in a teaching program within the private sector where he simply does not have to deal with these type of conditions. To date, we have been unable to find anyone within our institution who is willing to commit the effort necessary to survive in this system.

We have had another major problem in providing leadership for the Radiology Service. Two years ago, we recruited a new Chief of Service after a five year search. Part of the problem in that search related to the sorry state of the equipment in radiology, the difficulty in hiring high quality X-Ray technicians, and the very low salary allowed in the VA for a specialty that is well compensated in the private sector. We were pleased with our recruitment and felt the generous support we provided in a teaching agreement was money well spent. Unfortunately, because of continued deterioration in equipment and difficulties maintaining good staff, the Chief of the Radiology Service recently resigned to take a position in a private hospital.

Were his expectations unreasonable? Did his concerns have anything to do with the quality of patient care? You be the judge. Because of equipment problems, it is difficult to obtain chest radiographs of uniform quality. Thus, patients have had to go to other institutions or endure unconscionable delays for routine studies such as upper GI series or barium enemas.

As long as these problems exist, I cannot predict when we will be able to recruit a replacement. Thus far, we have been unable to entice anyone on our faculty to accept the position of acting chief unless a commitment is make to upgrade equipment immediately. Emergency support recently approved by the Regional Director, Mr. Zamberlan, for replacement of one fluoroscopy unit in FY89 is greatly appreciated, however, it is too late and only a fraction of the sum necessary to upgrade the equipment. To provide you with a basis for comparison, one of our major private teaching hospitals has a five year plan for replacement and upgrading its radiology equipment. In the next year, the capital expenditure for this purpose will be five and a half times the amount available to Lakeside, and over the life of the plan, the private hospital will spend in excess of $22,000,000. Few high quality radiologists are willing to accept the compromises required to work within the VA.

This Committee has expressed concern about the extent to which VA hospitals may have been shifting funds from nonrecurring accounts to support operations. That certainly has happened at Lakeside. For example, through the efforts of an excellent Chief of Staff recruited two years ago, a talented Director, and several new Chiefs of Service, the inpatient census is up. Despite a desirable decrease in length of stay, more surgical procedures are being performed, and outpatient visits have increased. The current system for reimbursing hospitals, however, is pegged to work units that were generated as much as 20 months ago. I know that the VA Central Office is striving to reduce that disparity to 6 months, but, in the meantime, hospitals improving their utilization figures do not receive sufficient operating funds to sustain the increased productivity.

The cost of delivering care at Lakeside in 1988 is higher than it was 20 months ago not only because of the increased volumes, but also because of higher costs for supplies, equipment, and personnel. There is a nursing shortage in Chicago, requiring that competitive salaries and benefits be provided to attract new hires. Recently, Lakeside lost six nurses and had to close three critical-care beds; an important contributing cause was the congressionally mandated requirement to institute paid parking for its employees. So far, this is the only one of the four VA hospitals in the Chicago area forced to implement this measure.

Currently, the Lakeside Medical Center has had to use all of its financial reserves and reduce inventories to an alarming level. Routine supplies are lacking on many nursing units and the pharmacy shelves are poorly stocked. There is no question that continuation of this situation could seriously jeopardize the minimum quality of care that can be tolerated--not only because of the lack of a specific item of equipment or adequate supplies--but also because dedicated care-givers cannot be expected to continue to answer the call without evidence that their sacrifices on behalf of their patient are appreciated.

It undoubtedly is obvious that I am concerned about the present and future quality of care within the VA system. I would not presume to suggest that the only answer to the problem is a larger appropriation for the VA's Department of Medicine and Surgery. There is no question that more money is needed at the operating level, but that might be accomplished by changing some administrative or policy decisions. For example, Congressionally mandated staffing levels might be anachronistic in today's health-care environment. The number of required beds in the system should be reviewed in order to move toward more cost-effective and otherwise efficient delivery of services in the ambulatory care setting. Finally, decisions to build new hospitals while others are under utilized and poorly equipped should be carefully justified.

I do not envy your task, but I appreciate the opportunity to share my thoughts with you. I, of course, will be happy to answer questions or clarify my statements.

BLINDED VETERANS ASSOCIATION
477 H STREET, NORTHWEST • WASHINGTON D.C. 20001 • (202) 371-8880

BLINDED VETERANS ASSOCIATION

TESTIMONY FOR THE RECORD

TO THE U.S. SENATE COMMITTEE ON VETERANS AFFAIRS

SEPTEMBER 9, 1988

BY THOMAS H. MILLER
DIRECTOR OF GOVERNMENTAL & COMMUNITY RELATIONS

Mr. Chairman and members of the Subcommittee, The Blinded Veterans Association (BVA) appreciates this opportunity to present our views on the Veterans Administration's statistics, policies and administration of hospital bed leves and the impact of shortages of health care professionals on the quality and quantity of health care delivered. Blinded veterans, like nearly all others in the veteran community are becoming increasingly concerned and skeptical regarding the VA's ability to meet the increasing demand for health care in the current environment of rapidly diminishing resources. Although we are told that the VA is in great shape and has more money than ever before, one only has to visit a VA Medical Center or Outpatient Clinic to learn that services are being drastically curtailed, due to shortages of professional staff, reductions in FTEE, or freezes on positions that have become vacant. Beds are being closed and even entire wards are shut down because Medical Centers do not have sufficient staff to operate them.

1. Mr. Chairman, BVA is deeply concerned that all veterans in need of hospital care receive quality care in a timely fashion. Obviously, we are especially concerned about the availability of rehabilitation beds for our nation's blinded veterans. It is this issue we would like to address today.

The Veterans Administration (VA) operates eight Blind Rehabilitation Training Programs within the 172 Medical Centers. Five of these programs are referred to as Blind Rehabilitation Centers and three are known as Blind Rehabilitation Clinics. Each program offers comprehensive, residential blind rehab training designed for distinct populations of blinded vets. The Center Program is designed for blinded veterans who can tolerate a faster paced more demanding rehab program. The Clinic Program on the other hand is especially designed for those blinded veterans with multiple disabilities and medical problems which necessitate a more individualized and slower paced program. The number of beds operated by Clinics and Centers tend to vary. Below is a list of the eight programs, their location, and bed capacity.

BLIND REHAB CENTERS

1. The Western Blind Rehab Center, (WBRC) VAMC Palo Alto, CA (30 beds)
2. The Central Blind Rehab Center (CBRC) VA Hospital Hines, IL (30 beds)
3. The Eastern Blind Rehab Center (EBRC) VAMC Westhaven, CT (25 beds)
4. The Southeast Blind Rehab Center (SBRC) VAMC Birmingham, AL (30 beds) and
5. The Blind Center at VAMC San Juan, PR (This facility is currently an outpatient program, interim to completion of construction of a 120 bed nursing home care unit, in which ten beds have been designated for a blind rehab center.)

BLIND REHAB CLINICS

1. VAMC American Lake Tacoma, WA (12 beds),
2. VAMC Waco, TX (15 beds), and
3. VAMC Westhaven, CT. (15 beds planned; currently using 5 Center beds) This last facility has not yet been fully implemented and was transferred from VAMC North Hampton, MA effective October 1, 1986. Currently the clinic uses five beds designated for the center, so in reality the Center has only 20 beds

available to it rather than the 25 it is supposed to be authorized. Inasmuch as the Puerto Rico facility is not yet operational, it will be excluded from further discussion in terms of the remainder of this statement.

Since the opening of the first VA Blind Rehab Center at Hines 40 years ago, the BVA has been an extremely strong supporter of the VA program and is the first to say the VA program is the finest in the world. We were instrumental in encouraging the VA to assume the responsibility for the care and rehabilitation of war blinded veterans after World War II. Possibly for the first time, we are gravely concerned for the future of the Blind Rehabilitation Service in the VA.

2. Two weeks ago, the BVA conducted a telephone survey of the seven BRC's in the Continental U.S. and were very disturbed to learn that 698 blinded vets are currently on waiting lists for admission to Blind Rehab. The existence of a waiting list is not necessarily a concern to us, but the size is because it is an indicator of how long a veteran will have to wait before being admitted for training. We learned that a veteran may have to wait from three months to as long as fifteen months (See Appendix A) before admission, depending on the facility. There are a number of factors which are influencing the current waiting list that we feel are relevant to this hearing and therefore of interest to you.

2.1 The number of applications is increasing due to the rapidly increasing incidence of blindness in the aging veteran population. We have testified to this phenomena many times in the past, encouraging the VA to plan accordingly. For several years we have called for the construction of a new 30 bed Blind Center to be located at VAMC Dallas, TX.

2.2 All of the existing beds designated for blind rehab either are not now available or at some time during this past year have not been available due to staffing shortages. At least four of the programs have deliberately kept the bed census below capacity because they did not have sufficient staff to teach the vets. This has also resulted in longer length of stays because staffs have been stretched so thin. Blind rehab is a unique discipline requiring one to one teaching in order to maximize the learning experience for the blinded vets. Several factors have contributed to the staff shortages including recruitment and retention problems, cuts in FTEE in some cases and freezes on vacancies in others.

In the past, VA was the most attractive employer for Blind Rehab Specialists with Masters Degrees, but this is no longer the case. VA has serious problems competing with the private sector and state agencies for the most highly qualified professionals. The VA is also experiencing difficulty in retaining professionals because more attractive opportunities have presented themselves outside the VA. When vacancies do occur it takes much longer to fill them with qualified professionals, and lengthy delays may result in holding down the bed census.

2.3 Cuts in FTEE or freezes on vacant positions have also plagued several of the programs. EBRC for example, has suffered several cuts over the years, which have left them short staffed and they will be required to take an additional cut of 2.8 FTEE. American Lake currently has three vacancies they are not permitted to fill and as a result are only operating 9 of their 12 beds. Last FY Waco was only able to operate 10 of 15 beds due to problems in recruiting. CBRC also has experienced problems in recruiting, resulting in holding down bed census. The most glaring problem exists at VAMC Westhaven, CT. As mentioned above, the Clinic was transferred there almost two years ago with absolutely no prior planning. It had previously been a ten bed program at VAMC North Hampton and those beds and ceiling were transferred to Westhaven, supposedly to prevent the program from dying. As of this date, none of those beds are operational and the Clinic has limped along using five beds designated for the Center.

The Five Year Facility Plan for Westhaven Blind Rehab Service calls for a fifteen bed Clinic and a thirty bed Center, but that is down the road some three to five years. This is totally unacceptable and reflects a total lack of sensitivity to the rehabilitation needs of blinded veterans. This failure in planning has resulted in the Center having only twenty beds authorized which further delays veterans being admitted to the Center Program and in reality, due to staffing shortages, only 16 or 17 beds are operational. There is a crying need to accelerate the Five Year Facility Plan which would result in the activation of 20 additional beds. This is nearly the equivalent of establishing another Center. Currently between the two Programs there are 226 blinded vets awaiting admission and a service connected (SC) vet must wait 8 months and a non-service connected (NSC) vet must wait 15 months. We have no way of knowing just how many vets have refused referral because of the incredibly long waiting period and we were shocked to learn that 6 blinded vets have died while awaiting admission. Had those vets been admitted more promptly, and their total health care needs monitered during training they might be alive today.

2.4 Another factor which has significantly impacted the length of the waiting list has been loss of FTEE at various facilities or the freezing of vacant positions. Although the Blind Rehab Program is regional in nature, the local Medical Center has to bare the full financial responsibility for the program. Also when a local VAMC is required to make cuts in FTEE, those housing BRC's have expected the BRC to take a full hit along with other services. We feel very strongly that because of the regional nature of the BRC program, any cuts should be shared by the entire region. This would minimize the impact on the blind program enabling it to operate at full capacity. In fact, Mr. Chairman, the VA does have a Circular 10-87-117, dated October 6, 1987 (See Appendix B), that directs this very kind of distribution of cuts. Unfortunately, the VA seems to be ignoring its own directives when it comes to Blind Rehabilitation.

2.5 The special training needs of blinded veterans, enrolled in either vocational or educational training or employed for computer evaluation and training, also are contributing to the time all applicants must wait for admission to WBRC and CBRC. These two Centers are attempting to offer informal, within existing resources, a Computer Evaluation and Training Program (CETP) and have set aside two beds that have been designated for the regular adjustment to blindness program. Consequently, they have two fewer beds operational for the vast majority of veterans applying for the regular program. BRS submitted a proposal last FY that would provide for the establishment of two formal CETP in FY89 and two in FY90. The proposal called for 5 additional FTEE for each program in addition to 2 additional beds. This proposal was denied by VACO in the budget submission. A similar request has once again been made by BRS in the FY89 budget request, but we have little hope it will be approved. It appears likely that all new spending submissions will be reached regardless of merit. We feel that the CETP should be funded on merit alone, but the fact that it is also contributing to the long delays at the Blind Centers, reinforces the importance of establishing formally, such programs.

2.6 Construction projects at WBRC this year and EBRC last year have necessitated closing some beds during the project. These were necessary projects and we do not argue with the delays which they may have caused. Otner Centers tried to help out by accepting some of the veterans to reduce the delays and this was greatly appreciated.

3. As indicated above, recruitment and retention of highly qualified professionals has played a significant role in the problems confronting Blind Rehab Service. The VA has taken very positive action on two fronts in an effort to alleviate these problems.

3.1 They have approved Special Salary Rates for both the WBRC and EBRC. Both facilities feel this has helped immensely in their recruitment efforts. CBRC has not been so fortunate in that their request was rejected for lack of funds to support it. Now they find themselves, the "Grandaddy" of Blind Rehab, at a disadvantage in competing with its sister Centers for qualified professionals. We are hopeful that their request will be resubmitted and approved for the new FY.

3.2 The other initiative being pursued by VA is to upgrade Blind Rehabilitation Specialist positions, making them more attractive for recruiting and offer more in terms of long term career advancement opportunities.

We are encouraged by both of these initiatives, but they will mean nothing if positions continue to be cut or frozen.

3.3 Additionally, when cuts are absolutely necessary, they should be spread across the region to minimize the impact on special medical programs like Blind Rehab.

4. All is not well, Mr. Chairman in terms of availability of beds for blinded veterans, and there certainly is a strong demand for these services as can be seen by the numbers of veterans awaiting admission. We cannot stress strongly enough the importance of this training for the successful adjustment of blinded veterans. It is extremely difficult for me to adequately express just how important blind rehab was for me following my loss of vision in Vietnam. Suffice it to say without that training, I would not be here before you today. Can we afford to deny this kind of service to the thousands of other blinded veterans who can indeed benefit, If they are to get off pension roles and become tax paying citizens once again, Blind Rehab is the starting point before one can seriously consider vocational or educational rehabilitation. The VA has been the pioneer in the field and has served as the model world wide for Blind Rehabilitation. We need the help of Congress to maintain this position of leadership and excellence.

Again, Mr. Chairman, I want to thank you for holding this important hearing today and inviting us to testify. We hope our input will be helpful to the Committee, and as always I would be pleased to answer any questions you might have.

APPENDIX A

FACILITY	BEDS AUTHORIZED	 OPERATING	 NO. WAITING	WAITING PERIOD SC	 NSC
CBRC	30	29	75	4 MO.	4 MO.
EBRC	25	17	176	8 MO.	15 MO.
SBRC	30	30	138	4 MO.	4 MO.
WBRC	30	30	142	3 MO.	10 MO.
AMERICAN LAKE	12	9	67	6 MO.	6 MO.
WACO	15	15	50	3 MO.	3 MO.
WESTHAVEN		5	50	12 MO.	12 MO.

APPENDIX B

Veterans Administration
Department of Medicine and Surgery
Washington, D.C. 20420

CIRCULAR 10-87-117
October 6, 1987

TO: Regional Directors; Medical District Directors; Directors, VA Medical Center Activities, Domiciliaries, Outpatient Clinics and Regional Offices with Outpatient Clinics

SUBJ: Blind Rehabilitation Centers and Clinics (RCS 10-0773)

1. PURPOSE: The purpose of this DM&S Circular is to provide designated VA facilities with policy guidelines regarding Blind Rehabilitation Centers and Blind Rehabilitation Clinics. This includes organizational alignment, specialized nature of programs, staffing requirements, blind rehabilitation staff roles, application procedures, admission and reporting requirements. This DM&S Circular is a new permanent issue and will be incorporated into M-2, Part I, by expiration date.

2. BACKGROUND: Blind Rehabilitation Centers were established to provide comprehensive adjustment to blindness training in a residential setting to blind veterans. The Centers also offer special programs including low vision training, electronic reading aid (ERA) training, electronic travel aid (ETA) training, and evaluation and training with computers/computer assisted devices. The Blind Rehabilitation Clinics were established to provide adjustment to blindness training and services to those blind veterans who have additional problems (i.e. psychological, medical, social, etc.) which prevent them from participating in a Center program. Each Center and Clinic provides a specialized program and serves as a resource to a multi-region catchment area.

3. POLICY:

a. In a health care facility where a Blind Rehabilitation program currently exists or is to be established, the program will be established as "Blind Rehabilitation Service (124)" reporting to the Chief of Staff. The Chief of the Service will be a blind rehabilitation specialist who will have operational and programmatic responsibility for the program. A physician will be assigned to the Service with responsibility for the health care needs of the blind veterans participating in the program.

b. In a health care facility where a Blind Rehabilitation Center and Clinic exist, both will constitute the Blind Rehabilitation Service with the Chief of the Blind Center being the Chief of the Service. However, the Center and Clinic will be physicially separated. This separation will include patient rooms, day rooms and skill teaching areas. Common utilization of the Low Vision Clinic is appropriate.

4. ACTION:

a. Specialized Nature of the Program: VA Blind Rehabilitation Centers and Clinics will offer a highly specialized rehabilitation program in a residential setting to blind veterans. Each facility will serve a multi-region area (see Attachment A) and employ a staff skilled in this unique discipline. Because of the unique nature of the program, teaching on a one-to-one basis must be maintained.

THIS CIRCULAR WILL EXPIRE OCTOBER 6, 1988

b. Recommended Staffing: In order to accomplish the mission of Blind Rehabilitation, recommended minimum staffing limits are: Centers--1.6 staff per bed, Clinics--1.2 staff per bed. (Training at Centers consist of six one hour periods daily. The Clinics are smaller units and the severity and nature of the Clinic patient's condition generally results in 20-30 minute training segments. This permits more flexibility in staff/patient scheduling and allows a lower staff/patient ratio.) These minimum limits must be met in order to ensure quality care and optimal length of stay. Because of the multi-regional nature of the programs, any proposed staffing reductions due to decreasing resources should not be imposed on the Center or Clinic. The reduction shall be dispersed throughout the multi-region service area to minimize the impact. In facilities where past reductions have occurred, efforts will be made to restore the staffing to previous levels.

c. Role of the Staff at a Blind Rehabilitation Center/Clinic: The role of the blind rehabilitation staff is to assess rehabilitation needs, develop and implement individual rehabilitation plans, coordinate support services in a team approach and make recommendations to referring facility concerning rehabilitation program follow-up.

d. Application, Procedures and Admissions: All applications for blind rehabilitation will be sent to the Blind Rehabilitation Center nearest to the referring VA facility. An Application Review Committee will determine whether the applicant is a Center candidate or a Clinic candidate. The committee will be chaired by the Blind Center Assistant Chief and will act as a multidisciplinary advisory group consisting of the Blind Center's physician, nurse, psychologist and social worker, with consultation from psychiatry as needed. The Application Review Committee will refer appropriate Clinic candidates to the Clinic nearest the referring facility. All applications rejected by Clinics will be forwarded to Central Office Blind Rehabilitation Service (124) for further review.

e. Admissions: All blind veterans are eligible for admission to a Blind Center or Clinic if they can benefit from the program. Blind veterans may benefit in varying degrees from blind rehabilitation according to their limitations caused by other mental or physical problems. The Chief of the Clinic will make the determination whether the veteran has the potential to benefit from this program or not. This will be done with consultation and advice from the physician and nursing staff regarding any medical conditions that may exist. Those applicants who are questionable will be admitted for an evaluation period in order to assess the potential rehabilitation benefit that might be expected.

f. Reporting Requirements:

(1) The Blind Rehabilitation Centers and Clinics will submit RCS 10-0086, a Quarterly Report of Blinded Veterans and Blinded Military Personnel who Receive Blind Rehabilitation at a VA Blind Rehabilitation Center or Clinic.

(2) The Blind Rehabilitation Center and Clinic Chiefs will submit a semi-annual statistical report to the Director, Blind Rehabilitation Service (124), Central Office. See Attachment B. RCS 10-0773 is assigned to this report.

CIRCULAR 10-87-117
October 6, 1987

5. REFERENCE: M-2, Part I, Chapter 18.

6. RESCISSIONS: This DM&S Circular will be rescinded. October 6, 1988.

7. FOLLOW-UP RESPONSIBILITY: Assistant Chief Medical Director for Clinical Affairs (124).

Arthur J Lewis MD
ARTHUR J. LEWIS, M.D.
Deputy Chief Medical Director

Attachments

DISTRIBUTION: COA: (10) only
SS (124) FLD: RD, MDD, MA, DO, OC & OCRO-1 each plus 200-2
EX: Boxes 44-6 & 88-2, Boxes 104, 60, 54, 52-1 each & 63-5

CIRCULAR 10-87-117
October 6, 1987

ATTACHMENT A

The Blind Rehabilitation Centers are located at VAMC's:

Birmingham, Alabama	serving Regions 2, 3 and 7
Hines, Illinois	serving Regions 2, 4 and 5
Palo Alto, California	serving Regions 5, 6 and 7
San Juan, Puerto Rico	serving Region 1 (Puerto Rico and Virgin Islands)
West Haven, Connecticut	serving Regions 1 and 2

The Blind Rehabilitation Clinics are located at VAMC's:

American Lake, Tacoma, Washington	serving Regions 5, 6 and 7
Waco, Texas	serving Regions 3, 4, 5 and 7
West Haven, Connecticut	serving Regions 1, 2, 3 and 4

CIRCULAR 10-87-117
October 6, 1987

ATTACHMENT B

BLIND REHABILITATION
SEMI-ANNUAL REPORT
(Reporting Period)

I. Total Admissions

II. Programs

- A. Regular
- B. Other
  - 1. ETA
    - a. List type
  - 2. ERA
    - a. List type
  - 3. Computer
    - a. List type

III. Average Daily Census

IV. Occupancy Rate

V. Turnover Rate

VI. Average Length of Stay

- A. Regular
- B. Other

VII. Average Age

VIII. Age Range

0-19
20-29
30-39
40-49
50-59
60-69
70-79
80-89
90-00

IX. Veteran Status

- A. Service-connected
  - 1. Blindness
  - 2. Other
- B. Nonservice-connected
  - 1. A&A
  - 2. Pension only
  - 3. Peacetime (or no pension for other reasons)

X. Period of Service

- A. WW I
- B. Post WW I Peacetime
- C. WW II
- D. Post WW II Peacetime
- E. Korean
- F. Post Korean Peacetime
- G. Viet Nam
- H. Post Viet Nam Peacetime
- I. Military

XI. Admissions by State

- A. List
- B.
- C.

Opening Statement:

Senate Veteran's Affairs Committee

August 11, 1988

Norton Spritz, M.D.
Chief Medical Service
New York VA Medical Center

I am Dr. Norton Spritz, Chief of the Medical Service at the New York VA Medical Center and Professor of Medicine at New York University School of Medicine, and have served in this capacity since 1969. I appreciate the opportunity to appear before this committee.

I have been asked to focus my remarks on the impact of AIDS on the problem of funding medical care in the Veteran's Administration. My involvement with this issue arises from the special role that the New York VAMC plays in the care of patients with AIDS in the VA system, as well as our involvement in studies of the economic impact of that disease.

Of the approximately 60,000 cases of AIDS in the United States, 6% or 3600 have been patients in VA Hospitals. The New York VA has cared for the greatest number of these patients, 475 or 12% of the total seen in the VA. While our hospital continues to see more patients than any other VA Medical Center, the number of VA hospitals who care for large numbers of AIDS victims increases.

The following twelve hospitals-New York, West Los Angeles (Wadsworth), Bronx, San Francisco, Brooklyn, Miami, Houston, East Orange, San Juan, Washington, D.C., San Diego and Atlanta together account for 56% of cases. As of December 31, 1987 each had seen from 71 to 411 cases.

With the strong support of Central Office and our Regional Director, the New York VA, which treats nearly 1% of all AIDS patients in the country, has achieved national prominence as a center of excellence for inpatient and outpatient care as well as for its research.

We opened the first AIDS Unit in the system in January 1988. Its 16 bed capacity, at that time permitted us to care for the majority of our patients in that special setting. Our daily census of AIDS patients now, however, averages 26-36, even though we are also treating a greater number of patients in our special outpatient unit. This increase in patient load can be expected not only to continue, but to accelerate. The number of patients at our hospital and at similar installations can be expected to double by 1991.

In our institution, the AIDS patients are a group who have great need for care by the VA and are highly qualified to receive it. We recently surveyed the 32 patients with AIDS in our hospital on a single day and found that 3 were service connected, and the other 29 were category A- the group of non-service connected veterans with the least personal resources and designated by Congress to be most entitled to care in a VA Hospital.

It is against this setting that we must consider the budget projections for FY89. Our hospital, for instance, faces a decrease of more than $3,000,000 and possibly $5,000,000, and a reduction of approximately 69 FTEE in spite of this projected increase in AIDS, our large open heart surgery program, and the full range of services that we provide to our veteran patients. We are by no means atypical. Many stations face the same dilemma-increasing AIDS patients and decreasing resources with which to care for them.

This decline in resources results from two aspects of funding VA medical care. First, all installations share in the continuing diminution in real dollar funding for the VA that has occurred over the past decade. Second, the Resources Allocation Model (RAM) leads to a further decrease in resources for our hospital and many others, including several that face special stresses such as a large AIDS population.

While the validity of the RAM as a mechanism for distribution of resources in the VA, in general, remains controversial, it is the problem of AIDS that puts the defects of this reimbursement system into clearest focus. I should like now very briefly to outline the major problems that arise from applying RAM to the funding of AIDS, and to emphasize the significant underfunding that will be faced by those institutions confronted with a large number of AIDS patients if the RAM is applied without substantial supplementation of the funds allotted by that mechanism:

1. Under the Ram Model Reimbursement for Either Inpatient or Outpatient Care is Far Below the Actual Cost to the Hospital for the care of Their AIDS Patients:

The "Disease Related Groups" or DRG's under which reimbursement is determined under the RAM were established before AIDS was a significant issue. Patients with AIDS are categorized under those established groupings that most closely resemble their clinical situation, but which, in fact, define patients who are less sick and who require far less resources.

The inadequacy of these DRG designations for reimbursement for AIDS was dramatically documented by the VA's Task Force on AIDS established in 1987. By actually cost accounting the expenses incurred for all categories of AIDS patients in VA Hospitals in FY1987, the Task Force, in its preliminary report, found the actual cost for the care of these patients to be approximately $50,000,000, a figure in accord with similar data from other health agencies. Under RAM, reimbursement was $18,200,000, or a little more than one third of actual costs.

This deficit, and one similarly calculated for FY88, have led to a special appropriation for those hospitals who care for significant numbers of AIDS patients. As the number of AIDS patients increases and as the number of hospitals dealing with these patients grows, this supplement becomes even more crucial. Coupled with a real decrease in overall funding, loss or limitation of this supplement will spell disaster for those hospitals who care for the largest number of patients with AIDS.

Parenthetically, this enormous discrepancy between RAM reimbursement for AIDS and actual costs when determined by direct cost accounting may not be limited to AIDS. Many of us feel that RAM is similarly defective when utilized as a reimbursement tool for patients who, like those with AIDS, have complex and severe illnesses and who have the least personal resources to deal with them.

2. While the Number of AIDS Patients Increases Annually, The Ram Reimburses Hospitals for the care it Delivered Two Years Earlier:

The lag between the accumulation of data for funding under the RAM and the utilization of those data to distribute resources is a general weakness of the RAM. It becomes most serious, however, when applied to a rapidly changing situation such as AIDS. The RAM adjustments for FY89 will be based on the work output recorded by individual facilities during FY87.

The growing number of patients treated for AIDS at the New York VAMC illustrates the potential for underfunding produced by this lag. In 1987 we treated 146 inpatients with AIDS, who utilized 7137 hospital days. We also had 1190 outpatient visits. Compare these figures to those annualized from the first six months of 1988. During 1988 will have treated 204 inpatients, an increase of 39%; these patients will have utilized 8914 hospital days, an increase of 25%; and there will have been 1452 outpatient visits, an increase of 22%.

When assigning resources for FY89, RAM will take into account the workload of FY87, which, in the case of AIDS, ignores the marked increase already documented for 1988, and which will be even greater in 1989, the year for which the funds are allotted.

3. The RAM Doesn't Account for Important Changes in the Cost of Care for Patients with AIDS:

The RAM is based on the premise that the unit cost of individual disease groups will not change between the time when data is accumulated and the time when it is used to distribute resources among VA facilities. This premise is clearly not valid in the case of AIDS.

New and expensive drugs such as AZT appear on the scene and their applicability to various groups of AIDS patients broadens. This treatment costs more than $6000 per year. Paradoxically, its effectiveness in prolonging the lives of these patients increases the total cost of their care. While adding productive life to many AIDS patients, it also leads to increased hospitalizations both for complications of the underlying disease and for problems resulting from the drug itself.

These increasing costs are not taken into account under the RAM which assumes that costs for the care of patients in each disease category will be the same in the index year and the year for which funds are distributed.

The hospitals that bear the largest burden for the care of AIDS patients are also the large inner city institutions whose patients tend to be poor, lack social support systems and suffer from multiple and complex medical problems. The proposed budget will make it difficult to find the resources for their care, even without the problem of AIDS. If one adds the burden of AIDS patients, whose care is even less well funded, care for both those with AIDS and the other patients we serve will surely fall below acceptable standards.

ALAN CRANSTON, CALIFORNIA, CHAIRMAN

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United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510-6375

August 19, 1988

Dr. Elizabeth Rogers
Chief of Staff
Baltimore Veterans' Administration
Medical Center
3900 Loch Raven Blvd.
Baltimore, Maryland 21218

Dear Dr. Rogers,

This is to confirm the invitation previously extended to you on my behalf by the staff of the Senate Committee on Veterans' Affairs to participate in the Committee's September 9, 1988, oversight hearing on the adequacy of VA resources (funding and personnel) to meet current and future needs of patients within the VA health-care system. This hearing will begin at 8:00 A.M. in Room 216 of the Hart Senate Office Building.

The Committee is interested in your appearing at the hearing so as to respond to questions regarding the VA's capability to meet veterans' health-care needs during the remainder of FY 1988 and in FY 1989. Regarding your individual facility, it would be appreciated if you bring written data in response to the following matters.

1. The (a) projected costs for FY 1988 and for FY 1989 resulting from the enactment of Public Law 100-322 for (1) the increases in total reimbursements and administrative costs for the beneficiary travel program (and the annual totals for each), (2) registered nurse Saturday premium pay, (3) State home per diem increases, and (4) outpatient care for those for whom care was mandated in the new law, and (b) funding specifically provided to your facility for these costs in FY 1988 and projected to be provided for in FY 1989.

2. For FY 1988 (as of June 30, 1988), projected for the remainder of FY 1988, and projected for FY 1989 the (a) costs for the payment of (1) special salary rates, (2) unfunded expenses for special drugs and other care for AIDS patients and for AIDS research, and (3) educational and training expenses resulting from the enactment of Public Law 100-322, related to the care and treatment of AIDS patients, and (b) funding specifically provided to your facility for these costs.

3. For FY 1988 (as of June 30, 1988), projected for the remainder of FY 1988, and projected for FY 1989 the (a) costs of implementing universal precautions as recommended by the Centers for Disease Control in Atlanta, Georgia, and required by the Occupational Safety and Health Administration for the purpose of protecting VA health-care workers against infectious diseases, and (b) funding specifically provided to your facility for these costs.

4. The total amount of funds shifted in FY 1988 (as of June 30, 1988), projected to be shifted for the rest of FY 1988, and projected to be shifted in FY 1989 from all non-recurring accounts, listed separately, to cover current and anticipated operational needs (please describe them).

5. As of September 30, 1987, and June 30, 1988, the total number of beds, broken down by the number of (a) critical care beds, (b) acute medical/surgical beds, (c) acute psychiatric beds, (d) long-term psychiatric beds, and (e) intermediate and nursing home care beds currently not available for patient admissions. Please break down the data according to the following reasons: (1) staffing shortages due to (A) recruitment difficulties and (B) lack of funds, (2) lack of other operating funds to support available beds, (3) then current construction or renovation projects, (4) decreased demand for beds, and (5) other reasons (please specify).

6. As of January 29, 1988, and June 30, 1988, the median and average waiting times for non-emergent outpatient appointments in each of the following clinics: general medicine, general surgery, orthopedic, ophthamology, cardiology, urology, mental hygiene, and substance abuse.

7. As of January 29, 1988, and June 30, 1988, the median and average waiting times for non-emergent inpatient admissions to general medicine, general surgery, orthopedics, urology, acute psychiatry, long-term psychiatry, PTSD in-patient units, substance abuse treatment units, and intermediate and nursing home care beds.

8. As of January 29, 1988, and June 30, 1988, the median and average waiting times for admission for non-emergent cardiac surgery, orthopedic surgeries requiring prostheses, and intraocular lens implants.

9. For FY 1987 and FY 1988 (as of June 30, 1988), if your facility has its own cardiac surgery capability, the number of patients being referred to both VA and non-VA sources for such surgery and the number of such referrals and their average cost.

10. For FY 1987 and FY 1988 (as of June 30, 1988), the mean and median vacancy rates for each of the following personnel categories: Psychiatrists, radiologists, anesthesiologists, registered nurses, licensed practical nurses, pharmacists, occupational therapists, physical therapists, and respiratory therapists.

11. An estimate of the dollar reductions in inventories for drugs, medical supplies, and prosthetics during FY 1988 (as of June 30, 1988), and the number of times your facility has been depleted of critical items or medications or has experienced critical shortages of these items or medications during FY 1988.

12. The current level of funds available to support contract community nursing home care payments for the balance of FY 1988 and the projected amount that will be available in FY 1989.

13. For FY 1988 (as of June 30, 1988), the rate of surgical postponements and of cancellations due to staff shortages and an estimate of the average delay involved for postponements and what proportion of the postponements involved more than one postponement for a particular veteran.

If you have any questions or would like additional information, please contact Sandi Isaacson or Kristine Hardy of the Committee staff at (202) 224-9126 (FTS 224-9126).

With best wishes,

Sincerely,

Alan Cranston
Chairman

The attached letter was sent to Dr. Elizabeth Rogers and the following 8 field witnesses:

Ms. Rowena Bishop
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Ms. Carol Coulter
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SUBJ: Oversight Hearings - U.S. Senate Committee of
Veterans Affairs

1. Following are additional costs and additional allocations ensuing from enactment of PL100-322 and new workloads associated with AIDS at the Baltimore VAMC:

	COST FY88	FUNDED FY88	COST FY89	FUNDED FY89
BENEFICIARY TRAVEL*	15,000	49,616	60.000	0
SATURDAY R.N. PREMIUM PAY	37,156	28,786	96,000	0
SPECIAL SALARY RATES	312,156	248,300	568,256	248,300
AIDS RELATED EXPENSES				
PHARMACY	85,000	85,000	165,000	0
LAB TESTING	20,188	15,000	30,282	0
EXTENDED LOS	62,000	0	184,000	0
AIDS RESEARCH				
EQUIPMENT	134,000	134,000	0	0
CORE SUPPORT	252,000	252,000	252,000	252,000
ADMIN. SUPPORT	35,000	0	70,000	0
AIDS EDUCATION, TRAINING	1,724	1,724	81,803	0
UNIVERSAL PRECAUTIONS	278,412	0	278,412	0
MANDATED OUTPATIENT WORKLOAD	187,000	0	750,000	0
TOTAL PL 100-322 COST/FUNDS FY 88	1,419,645	814,426		
FY 89			2,535,753	500,300

*Beneficial travel shortfall this year was $288,000 before implementation of PL100-322.

1. (a) (3) This medical center does not support any State Homes. The State Home in Charlotte, MD is supported by VAMC Washington, DC as it falls under their area of jurisdiction.

(4) Projected workload for those veterans for which outpatient care is mandated by PL 100-322 is estimated at 8,000 - 12,000 more visits per year. There is significant concern for those specialty clinics already heavily used, such as Primary Care, Cardiology, Gastroenterology, Orthopedics, and Neurology. The cost of this care, at $62.61 per visit, is $500,000 - $750,000.

2. (a) (3) The AIDS epidemic has put a formidable burden on the educational resources of this medical center. Public Law 100-322 mandates that the medical center provides an information and training program for VA employees and beneficiaries relating

to AIDS. To fulfill this mandate will require a substantial commitment of local resources. First the education requirement of our staff must be met. To this end the MARMEC has sponsored and provided a training of trainers workshop for AIDS. Three attendees from this facility have undergone this training. This three day intensive course prepared the trainers to educate staff about HIV and AIDS in a variety of ways. To be effective such training should be given to all VA employees. Estimating approximately two hours per person per year the indirect cost of this training becomes $25,961 per year for the time lost by employees for training purposes and approximately 90 - 270 hours per year of trainer time (or $1,298 - $3,842 assuming a GS-9 to GS-11 trainer). The direct cost of travel for these trainers was $1,506. This was provided by the MARMEC. Three days of authorized absence were provided by the medical center to allow attendance of this course. This overview information does not include information specific to direct healthcare providers who will need additional training in proper techniques of patient management as well as the specific techniques of universal precautions which are henceforth necessary. This type of training will place a recurrent burden on the medical center because of the constant new developments in AIDS and the turnover of personnel.

Second, patient education must take place to all beneficiaries. HIV positive patients and those with AIDS require counselling and education on issues directly related to the infection and those related to transmission. Beneficiaries at high risk of HIV infection but as yet HIV negative require extensive education in ways to minimize risk of infection. Low risk beneficiaries need education to maintain their low risk and to overcome fallacies related to HIV-AIDS. Families of many beneficiaries will also require education. Because of the high incidents of HIV positive cases in our population an ever increasing number of AIDS-HIV cases are being treated at the center. The Federal Building Outpatient Clinic provides a methadone maintenance program and therefore has been also a site of exponentially increasing issues relating to AIDS. To provide adequate time for patient education at both sites it is estimated that two full time health educators will be needed in the immediate future. Currently existing personnel are performing these services. The cost of this aspect of AIDS education is estimated at $52,000 per year.

This totals to $81 803 the amount of money needed yearly to perform the direct mandate of P.L. 100-322 to provide education to employees and patients.

2. (b) The Baltimore VAMC is one of six nationally designated HIV Research Centers for the VA. As such, it received money for equipment and research personnel, however, it has received no funds for the increased activity in Supply, Fiscal, and Personnel to administratively support this research.

3. The cost for implementing universal precautions are estimated as follows:

disposal of infectious wastes	
two additional FTEE requested ----------------	$ 34,000
additional infectious waste bags ------------	10,000
additional isolation gowns --------------------	1,500
additional gloves -----------------------------	104,728
goggles ---------------------------------------	500
zip lock bags ---------------------------------	720
disposable ambu emergency bags ----------------	15,600
disposable gowns/linens -----------------------	111,364
total -----------	$ 278,412

These costs do not include the cost of personnel time and materials for hospital wide in-service education. The cost of gloves is a particular problem since not only has the need doubled, but the price per box of gloves has increased from $3.86 to $12.00 per box. The two additional FTEE would be used to sterilize all additional infectious waste generated by implementation of universal precautions. Unfortunately, no specific funding has been provided to our facility for these costs.

Within Surgical Service alone, the cost of implementing universal precautions would be to use disposables on all high risk cases and all cases where there would be a high likelihood of exposure to blood and body fluids. This would include most of the major cases in general surgery, vascular, orthopedic, GU, and ENT. Approximately $60,000 per year is required for a barrier system which includes scrub suits, and lap packs, and $36,000 per year for gloves.

4. Despite being an efficient, sparsely staffed, highly productive medical center and a "RAM winner," the Baltimore VA Medical Center has had major cuts in its recurring budget over the last four years which is now interfering with its ability to meet the patient care needs.

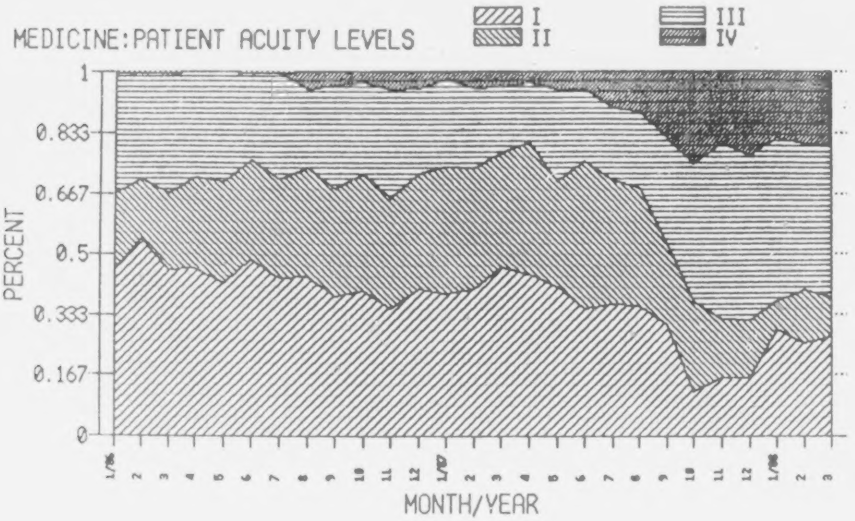
4

VAMC BALTIMORE, MD
HISTORICAL FUNDING

FISCAL YEAR	STARTING MEDICAL CENTER BUDGET RECURRING	GAINS	LOSSES	NO GAINS AND SHORTAGES	ADJUSTED MEDICAL CARE BUDGET	REAL CHANGE TO RECURRING BUDGET
FY 1986	$31,196,765	$2,267,086	($1,496,712)	($859,923)	$31,107,216	($89,549)
FY 1987	$31,967,139	$6,204,221	($4,861,720)	($2,065,317)	$31,244,323	($722,816)
FY 1988	$33,254,125	$3,751,884	($95,739)	($3,830,586)	$33,079,684	($174,441)
FY 1989	$36,652,703	$919,605	($887,548)	($758,868)	$35,925,892	($726,811)

-$1,713,617

As shown above, erosion of the recurring base now amounts to over $1,713,617 over the past 4 years. Losses from the recurring base have occurred due to COLA, DCHP savings, VA internal taxation for MEDIPP, within grades, homeless program, pay raise annualization, increased cost and usage, presidential budget cuts, 1% productivity, 5% salary cut, beneficiary travel, contract and home dialysis underfunding, and fee pharmacy underfunding. This erosion in funding has occurred at a time when the patient acuity level is increasing.



5

The net effect of this budget shortfall is that, with the target medical care budget of $37 million projected for the Baltimore VA Medical Center in 1989, we will either be forced to reduce beds to an intolerably low level of less than 140 ADC, or else, reduce the work force by 105 FTE to meet the all-other cost accounts. This augments the continuing problem of unsupportable FTE over the past four years.

BUDGET SHORTFALL

MED CARE BUDGET	ADC	PTS TRT (ADC x 365 / 9.5)	A/O COST ($1710 per Pt Treat)	P/S AVAIL	AFFORD-ABLE FTEE @ $35,000	FTEE SHORT @ 827	BUDGET SHORT
$37,085,452	180	6916	$11,826,000	$25,259,452	721.7	-105.3	($3,685,548
$37,085,452	170	6532	$11,169,000	$25,916,452	740.5	-86.5	($3,028,548
$37,085,452	160	6147	$10,512,000	$26,573,452	759.2	-67.8	($2,371,548
$37,085,452	150	5763	$9,855,000	$27,230,452	778.0	-49.0	($1,714,548
$37,085,452	140	5379	$9,198,000	$27,887,452	796.8	-30.2	($1,057,548

HISTORICAL UNSUPPORTABLE FTEE SEPT 7, 1988

FY	UNSUPPORTABLE FTEE
1985	27.6
1986	38.3
1987	34.0
*1988	53.1

* PROJECTED WITH BEGINNING OF YEAR FUNDING AVAILABLE
ALL OTHER CALCULATIONS ARE BASED ON FTEE SUPPORTED BY NON-RECURRING FUNDS AND "MINIMUM" A/O FUNDING.

In FY 1988 the total amount of money shifted from non-recurring accounts to cover current and anticipated operational needs were:

	Percentage	Amount
Replacement Equipment Funds	70%	125,000
Additional Equipment Funds	61%	110,000
M&R Projects	85%	274,000

These shifts have meant needed equipment and projects have been delayed creating an untenable situation. In FY 1989, the situation is not only worse financially, but also the need for the equipment is even more significant.

	Percentage	Amount
FY 89 Replacement Equipment	100%	119,488
FY 89 Additional Equipment	100%	103,485
FY 89 M&R Projects	100%	235,000

This will create an impossible situation if we are unable to utilize these accounts for the purpose that they were originally designated. For example, the x-ray processing equipment in our Screening room has been broken and irrepairable. Since there is no money to replace this equipment patients entering our Screening area in need of emergency diagnostic x-rays must be transported often with personnel whose qualifications may be inadequate to the Radiology Department at the distant end of the medical center. More recently, there was a 74 year old veteran who was suspected of having a heart attack but was transported to another emergency facility because of our inability to admit him to our CCU. Had we been able to purchase telemetry equipment, we could have transferred a more stable patient from CCU to a telemetry bed on the ward. This would have freed up a CCU bed for an admission. This telemetry equipment has been our number one priority for several years. Additionally, the medical center's only bronchoscope broke approximately eight months ago. Our biomedical engineering department has stated it is irrepairable. There are currently no funds available to replace this necessary piece of equipment.

5. Number of beds available:

	Authorized Beds	9 30/87	6/30/88	8/29/88
Critical Care	21	21	15	19
Med/Surg/Neuro	239	174	145	132
Acute Psych	31	26	26	26
Long-term Psych	N/A			
Intermediate & NH	N/A			
TOTAL	291	221	186	177

Of the 291 authorized beds, 20 beds have been closed for space for a new Ambulatory Surgery program and 5 beds for reducing overcrowding on our Psychiatry unit. There are, however, 89 medical and surgical beds closed due to a lack of all other operating funds, lack of Personnel funds, and lack of funds to contract (to counteract the nursing recruitment difficulties). As a result of these funding issues, we had to restrict 400 admissions this fiscal year as compared to FY 1987 despite a significant demand (VAMC Baltimore's discharges per 1,000 veterans is 1/2 other similar VA Medical Centers with the same average length of stay). In addition, with the recent decrease in the number of critical care beds and acute beds over the last three to six months we have had to spend a significant amount of time daily with the administrative and clinical staff to find beds for patients, to rearrange patients in critical care areas, and also rearrange operating room schedules on a daily basis. As such, cases are delayed and/or canceled because of lack of beds. Elective admissions for lung cancers and arterial bypass are postponed because there are no beds available. This situation is intensified because of nursing staffing shortages in the intensive care units as well as on the wards. In addition, because of the lack of funds, administrative services are not supported appropriately, and as such, nurses are forced to do non nursing duties in addition to their clinical and professional duties. Additionally, there are insufficient funds to adequately support the level of patient acuity in Baltimore.

6. Information concerning availability of appointments for January 29, 1988 and June 30, 1988 for non-emergent outpatient appointments is not available. The following information identifies the next available appointment through the computer as of September 1, 1988:

Primary Care - November 14, 1988
General Surgery - September 29, 1988
Orthopedics - October 31, 1988
Ophthalmology - September 18, 1988
Cardiology - November 7, 1988
Urology - September 16, 1988
Mental Hygiene - September 6, 1988
Substance Abuse - September 6, 1988
Gastroenterology - November 18, 1988
Neurosurgery - November 14, 1988
Neurology - December 13, 1988

On a daily basis, 10 - 15 patients in our Screening area are entitled to and need new placement in our Primary Care or speciality clinics. The time lag for these appointments become disproportionately prolonged for non-emergent patients. For example, the tenth patient in need of a clinic appointment would receive the following appointments through the computer for:

Neurosurgery - December 5, 1988
Neurology - October 10, 1989
Orthopedics - November 17, 1988
Primary Care - December 19, 1988

Unfortunately, the official data does not represent the true picture. For instance, in the Mental Hygiene Clinic a shortage of psychiatric staff has resulted in very lengthy periods for patient reappointment visits. With over 900 patients on the clinic treatment roles, and daily unscheduled patient drop in/visits, the two FTEE of clinic psychiatrists available were not capable of providing quality, optimal care. Four to six month prescription refills for medication are not infrequent and treatment brevity is of concern to all. Scheduled appointments to see a psychiatrist are at quarterly to biannual intervals for many patients. At the same time, the Drug Dependance Treatment Program continues at capacity for methadone maintenance patients. New patients have been admitted to the program only as others depart. With an average of 110 patients on methadone, a third as many at any one time continue to request admission. This represents only the tip of the iceberg quantitatively because it is common knowledge in the community that our VA program is full. It also represents the tip of the qualitative iceberg because we are just not dealing with the multiple drug abuser and the cocaine/crack abuser due to inadequate staff availability.

In addition, the house staff is aware of the long waiting times for clinic appointments, and while not clinically appropriate, schedule return visits for three to four weeks beyond the time the patient should return. In many clinics patients can not be seen within a two to three month period of time. Some of these patients have been purposefully given four and six month return visits, and been told to come into the screening area should an emergency problem arise. The resident staff know the current waiting list and the waiting time for the clinics and compensate accordingly. If appropriate appointments were made at two and three week intervals the computer appointment schedule would be quite different.

7. The log of admissions for non-emergent surgical procedures is maintained by the Surgical subspecialities. At this time, the waiting period for non-emergent cases is as follows:

General Surgery	2 - 3 weeks
Orthopedics	8 - 12 weeks
Urology	2 weeks
ENT	4 - 5 weeks
Ophthalmology	2 - 3 weeks

A patient in Screening requesting and needing non-emergent acute Psychiatry admission will have to wait 7 - 14 days. There is always a list of five to ten veterans awaiting Psychiatry admission which are often delayed again and again by "more emergent patients". For every one veteran admitted, two to three others are delayed, referred elsewhere, or lost to attempts at outpatient follow-up due to multiple medical, psychiatric, social, and economic factors. We do not have long term psychiatry, PTSD, intermediate care, or nursing home care beds.

8. Information concerning availability of admission from January 29, 1988 and June 30, 1988 is not available. However, the waiting list in orthopedic surgery for prosthesis is approximately two to three months. Many of these patients have been evaluated months previously and deemed appropriate candidates for joint replacement. The resident and attending staff prioritize these patients on medical needs, but can only insert prostheses such as artificial hips or knees within our budgetary restraints. Those patients that are good candidates for surgical care are simply maintained on pain medication and relative bed rest until surgery can be performed. Another major problem that has compromised our care in this area is availability of physical therapy. In some of these patients, joint replacement is not done because there is an acute shortage of physical therapists. In order to have a successful joint replacement, acute rehabilitation with physical therapy is critical. Decreased physical therapy FTE funding this year at VA's in the Baltimore area compounded the increasingly difficult problem of physical therapy recruitment due to the noncompetitive VA salary scale.

In ophthalmology, the intra-ocular lens implants are limited by our funds to support this program. Patients are identified in the appropriate manner.

9. No cardiac surgery is performed at this VA Medical Center. Although this VAMC does not provide cardiac surgery, in FY 1988 to date 19 cases were referred to other VAMC facilities and 30 cases were referred to non VA hospitals (to include NIH). This VAMC has a memorandum of understanding with the University of Maryland Medical System to perform routine CABGs at a current cost of $12,750 per case. This sharing agreement could be expanded in our replacement medical center to include a combined VA/University of Maryland Cardiac Surgery team, operating on veterans in the VA and on non-veterans at the adjacent University Hospital.

10. The mean vacancy rates in FY 1987 and FY 1988 for each of the following personnel categories are:

	------- Mean Vacancy Rates --------	
	FY 1987	FY 1988
Psychiatrist	0 %	15 %
Radiologist	66	66
Anesthesiologist	0	25
Registered Nurse	26	17
Licensed Practical Nurse	37	26
Pharmacist	6	12
Occupational Therapist	----have no positions --	
Physical Therapist	50	vacant entire year
Respiratory Therapist	15	0

Recruitment of full-time, academically trained physicians in the subspeciality areas of Surgery, Radiology, Pathology, and Psychiatry has been difficult because of (1) Salaries non-competitive with medical schools or private practice, (2) Cramped and understaffed working conditions and, (3) unavailability of support supplies secondary to budget constraints. University salaries are usually double and private practice salaries are three and four times that which is currently offered by the VA. The amount of administrative work required in the VA is also significantly increasing and this is a significant deterrent to many individuals. In the past, research funding in surgery was easily available through the VA system, however, even this has significantly decreased and has lost a lot of its appeal to recruiting younger surgeons since the competition for research funds has significantly increased. The services have tried to keep medical care going by bringing in part-time physicians on a temporary basis to fill in the holes where possible. This approach has problems with inflexibility of schedules and difficulties handling non-emergent problem-solving and program development. In addition, caseload reductions occur as Orthopedic and ENT cases are scheduled depending upon the availability of attending staff. Frequently operations are canceled or postponed because of staffing problems. The problems contributing to this are multiple and include a lack of competitive salaries in the VA to maintain staff surgeons in a near full time capacity. The salary and benefits offered by the VA simply are not competitive either with the University, or with private practice in surgery, especially the surgeries of specialties. Other areas of personnel have adversely impacted on the surgical service. This includes registered nurses, physical therapists, respiratory therapists, and anesthesiologists. Recently one of our full time anesthesiologists transferred to another VA where the clinical load is considerably less. One of our full time nurse anesthetists has recently resigned because the salary offered in the private sector was nearly double what she was currently earning at the VA. One of our part time nurse anesthetists will be resigning in October to take a lucrative position in the private sector. Currently, there are no viable candidates for these positions.

Salaries for psychiatrists in the VA are no longer competitive with even the state hospitals in the Baltimore Metropolitan Area. A board certified psychiatrist can start with the state of Maryland at $80,000 per year, plus fringes, for a thirty five hour work week, with "no" outside work restrictions. Our existing vacancies have been hidden with the hiring of temporary, part-time psychiatrists with there major professional commitments elsewhere. Realistic lead time for hiring is six to eight months. Recruiting is realistic only for young psychiatrists right out of training to start in July. We are concerned that the best psychiatrists will leave for better opportunities and renumerations elsewhere after just a year or two. It was exceptionally frustrating this past May/June 1988 to have the year long successful recruitment efforts for two young, highly qualified psychiatrists placed in jeopardy because of acute budget constraints. Such action can totally destroy the reputation and credibility of our program, and would rapidly accelerate professional staff turnover, especially at the top.

11. During FY 1988 we estimate there has been a $550,000 reduction in inventories for drugs, medical supplies, and prosthetics. This figure may be broken down into the following:

Laboratory	$ 55,000
SPD	141,700
Dietetics	6,000
Engineering	42,500
Surgery	50,000
Radiology	17,000
Medicine	21,000
Prosthetics	17,500
Pharmacy	200,000
TOTAL	550,000

We have significantly reduced our on shelf inventory for pharmaceuticals. In pharmacy service we only have a seven day supply of medication instead of a 30 day supply or even a reduced fourteen day supply. We experience potential critical shortages of expensive drugs such as antibiotics and cardiology drugs because we are forced to buy less quantities more frequently.

In surgery, we generally have three or four vascular prosthesis on hand in case of emergency problems. With a decrease of funding, we purchase supplies as we run out of them. Occasionally, when an emergency case does come up we have to borrow a vascular graft from a nearby hospital and pay them back. This way of doing business could be avoidable if sufficient funds were available to support our activity and would decrease the amount of administrative work required to manage supplies in this manner.

Radiology, during normal operating times, tries to keep a four to six seek inventory of their expendable supplies. There have been times during the third and fourth quarter where their inventory has been down to less than one week. In fact, they were once down to their last package of x-ray film because their issue book could not be processed due to lack of funds. While they never totally ran out of supplies, the level has dropped to a critical point, raising anxieties that the x-rays being taken may be the last one taken in the hospital.

Recently, Medical Service used their last pacemaker. It was requested of the Resource Committee to decided whether Medical Service could obtain another pacemaker in case of a medical emergency. Such activities are compromising patient care when we have to wait until we run out of supplies before they can be replaced.

12. The current level of funds available to support contract community nursing home care payments in FY 1988 at the medical center is $1,245,000. Earlier in the fiscal year $30,000 was returned to help other VAMCs; however, as community nursing home placements were increased (to help ease the burden of closed beds), an additional $15,000 was needed in the fourth quarter. Community Nursing home placements were stopped for a two week period until the $15,000 was made available. As soon as the funding was obtained, four patients were placed in Community Nursing Homes. Future placements will include one patient for each discharged, plus one additional placement. Projected funding for FY 1989 is $938,156 with an ADC of 41 patients. This amount will result in stopping placements for an extended period since our current ADC in FY 1988 is 60.

13. We track operating room cancellations and found that the major reason for cancellation was lack of staff. We do not track the postponement of cases since they are not listed in the official OR poster. Approximately two or three cases per month are canceled because of staff shortages, either in the operating room, ICU, or on the floors. Another four to five cases per month are postponed because of known or projected staff shortages. These patients simply are not listed again for operation until there is a reasonable chance that they will be operated on. There have been three to four orthopedic patients over the last several months that have been posted three to four times and cancelled. The same is true of a vascular patient that was posted twice and cancelled both times because of lack of ICU beds and staffing.

Medical Center

3900 Loch Raven Blvd.
Baltimore MD 21218

Veterans Administration

September 19, 1988

In Reply Refer To 512/11

Honorable Alan Cranston
Chairman, Committee on Veterans' Affairs
United States Senate
Washington, DC 20510-6375

Dear Mr. Chairman:

As requested by Senator Murkowski, during testimony given on September 9, 1988, and in response to your letter dated September 12, 1988, following is a quick overview of some of the 1986 budget options that were considered by the CMD's Task Force on FY 89 operational shortfalls. First and foremost, the task force was called because the planned operating budget for FY 89 was thought to be short by $819 million. Because of allocations by congress, this has been reduced to a still very considerable $609 million shortfall.

Because of the continuing need for national fiscal constraints, it can be expected that even the shortfalls are appropriately funded, that the VA will be under continuing restraints for many years. To this end, I concur with the long-range strategy of the committee that there be a nationwide study of VA Medical Centers and Outpatient Clinics, their missions, and the veteran population served; that through this study, decisions be made on reducing missions and closing facilities where there is insufficient evidence of veteran need, so that these funds can be better utilized in areas of higher veteran need. This would require a bipartisan, nonparochial approach of Congress, Veteran Service Organizations, AAMC and others.

I also support the task force comments on funding methods. As Congress sets the priorities and entitlements, the Veterans Administration should be held to accurately projecting its needs to meet these entitlements, and funding should follow accordingly. The problem of lack of flexibility of local VAMC Directors to manage is most apparent when resources are as tight as they are, however, flexibility alone will not improve the resource situation. In regard to specific proposals:

Option A

1. MEDIPP and contingency funding: The VA, with the advice of Congress, directed a grassroots program of planning called MEDIPP. This program, to my knowledge, has never been funded by Congress. At a time when medical

"America is #1—Thanks to our Veterans"

centers cannot meet existing work loads and maintain state-of-the-art equipment, its inappropriate to further tax them for the purpose of beginning new initiatives. I think the MEDIPP planning process is a good process, but that it should not be continued unless there is funding to support it. I agree that a line item contingency fund should be sought in FY 91 in the out year budget.

2. It is wrong for the VA not to pursue high technology in joint venture acquisition of equipment. I would recommend the following of Option A.2. only if Congress is unable to fund the $109 million shortfall.

3. The VA has established regional programs with high capability and low mortality in the area of transplants. Kidney transplants are clearly state-of-the-art and are clearly life-saving. Heart/lung transplants are being more frequently with better and better survivals. As with the previous option, I think that transplants are an area that the VA should continue to show leadership and offer state-of-the-art service to its veterans. If, however, the $609 million shortfall is not corrected, it is a source of vertical cutting which will harm a smaller number of veterans for a larger volume of dollars returned to the system.

4. I do not support Option A.4. to recapture increased cost from target allowance, this is only a paper movement of money which doesn't exist anyway.

Option B

5. Descretionary work load - Uniformed distribution of dollars to assure that Category A patients are taken care of appropriately would be a positive step forward. Because the methodology would become important in determining how the system would work, I am hesitant to approve it without clear definition. I do agree that the internal system of resource allocation should be suspended until the VA develops new priorities for how to meet the care of the patients it is capable of treating.

6. Decentralized non-VA workload accounts: Although I agree that there may be some savings from decentralization of contract hospital fee, medical fee, dental and community nursing home care funds, I do not think these savings will be large. Report from various VAMC's in Region 2 and in other regions indicate that dollars available for community nursing home care is currently inadequate. Decentralizing these accounts would not make those monies larger.

7. Option B.7. should not be undertaken if there is any other way of making up the $609 million shortfall.

8. Restrict over-the-counter drugs for all patients: There are many patients who take over-the-counter drugs for non-medicinal reasons. Restricting these activities would save the VA money and probably improve the quality of patient care. There are patients who do not have the finances to buy their own medication, yet do need aspirin to prevent heart attacks or antacids for treatment of proven duodenal ulcer disease, or vitamins for established malnutrition. These patients should not be denied these therapeutic activities simply because medication is "over-the-counter."

9. Eliminate chronic outpatient home and fee-for-service dialysis: This would move cost from the VA to HCFA. As I see no net gain to the federal government or the patients, it is not a program I enthusiastically support.

10. Appeal congressional guidance to maintain employment at AIDS impacted VAMC's: As Congress has funded this section of PL100-322, this issue should be moot. It should be noted, however, that all VAMC's are impacted by AIDS, as the cost of instituting universal precautions has to apply to every medical center. These costs were not budgeted in Congress' allocation of the '89 budget.

11. Delay activations of newly constructed facilities: Delay of activations of newly constructed facilities does not make any sense. Would appear to both the patients and the taxpayers as though facilities are being inappropriately built and then not utilized to the maximum.

12. Payment for prescriptions: As many of the Category A patients have very low incomes, their ability to offset the cost of pharmaceuticals is limited. Although it would be a cost saving to the VA which could be applied to Personnel and all other cost, it must be recognized that co-payment for prescriptions will, in point of fact, reduce the number of patients who are receiving appropriate medications, a long-term decrease in the quality of care being afforded to veterans.

- Option C

13. Discontinue HCMI in homeless domiciliary programs: As I understand that this section of PL100-322 has been funded, as the homeless remain a problem in this country, I would not support this option. Were these programs not to be funded, they do not hold this high priority in my mind as direct patient care, and therefore, taxation of direct care patient programs to achieve these programs by the VA should not occur.

14. If PL100-322 has been funded by Congress, then I do not recommend withholding money for beneficiary travel. If this section has not been specifically funded, curtailment of beneficiary travel other than special mode might be considered. It is mandatory that the VA support the nurse bonus pay system as implemented by Congress, if even as a token acknowledgement of the crucial role which nurses play in the system.

15. Decentralized VACO accounts: These are small accounts and decentralization will probably mean the end of the upward mobility program for which the VA has developed notable recognition for its ability to help minorities move up through the system through appropriate education.

Option D

16. I agree with a moratorium on A76 studies, efficiency reviews, FDP's and other special studies during a time of special budget shortfalls.

17. Re-prioritize minor appropriation projects: As before, this activity should be undertaken only if there are no other means to meet the $609 million shortfall.

18. Mandated employment ceiling and personal services floor VA system needs: The 194,140 FTE assigned by Congress. In point of fact, it needs more FTE. Allocation of too many floors and ceilings, however, with inadequate salaries to cover the ceilings, does at time lead to some centers bringing on low pay, less than necessary FTE rather than the clinical FTE which the system needs.

The above options, if forced to take place because of the expected budgetary shortfalls, should all be activated at a VA Central Office level. This would allow for greater uniformity of treatment of veterans across the nation, rather than individual activitations of various options at individual medical centers. Activities from number C13 on will require administrative and/or legislative approval in order to enact.

Thank you for consideration of the acute problems which I think, indeed, are facing the VA this year. Your ability to help Congress recognize the true impact of the $609 million shortfall upon quality medical care is essential. I urge that the full $609 million restitution be made while the 100th Congress is still in session.

Sincerely yours,

E. Rogers

ELIZABETH L. ROGERS, M.D.
Chief of Staff

Medical Center

Wadsworth and
Brentwood Divisions
Wilshire and
Sawtelle Boulevards
Los Angeles CA 90073

**Veterans
Administration**

September 6, 1988

In Reply Refer To: W118

Honorable Alan Cranston
Chairman, Senate Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510-6375

Dear Mr. Chairman:

In response to requested data to be submitted at the oversight hearing on September 9, 1988, the following information is provided:

1. The projected (a) costs for the remainder of FY 1988 and for FY 1989 resulting from the enactment of Public Law 100-322 for (1) the increases in total reimbursements and administrative costs for the beneficiary travel program (and the annual total for each), (2) Registered Nurse Saturday premium pay, (3) State home per diem increases, and (4) outpatient care for those for whom care was mandated in the new law, and (b) funding specifically provided to your facility for these costs in FY 1988 and projected to be provided for FY 1989.

RESPONSE:

(a) The projected costs for the remainder of FY 1988 and for FY 1989 resulting from the enactment of Public Law 100-322 for (1) beneficiary travel is $63,000.00 for the remainder of FY 1988 and $320,000.00 for FY 1989. No increase in administrative costs is anticipated for either the remainder of FY 1988 or for FY 1989. (2) The projected costs for Saturday premium pay for the remainder of FY 1988 is $137,745.00 and $377,000.00 for FY 1989. Projections include Saturday premium pay for Licensed Practical/Vocational Nurses. (3) VAMC-West Los Angeles does not incur State home per diem costs. (4) Projected cost for outpatient care mandated by Public Law 32-100 is $34,290.00 for the remainder of FY 1988 and $137,160.00 for FY 1989.

(b) Funds provided to VAMC-West Los Angeles in FY 1988 for the above costs included: beneficiary travel program - $24,495.00; Saturday premium pay - $104,145.00; and $28,781.00 for outpatient care. Since the FY 1989 budget has not been received, funds projected to be provided in FY 1989 to cover these increased costs is unknown.

2. The current FY 1988 (as of June 30, 1988) and projected remainder of FY 1988 and all of FY 1989 (a) costs for the payment of (1) special salary rates, (2) unfunded expenses for special drugs and other care for AIDS patients and for AIDS research, and (3) educational and training expenses resulting from the enactment of Public Law 100-322, related to the care and treatment of AIDS patients, and (b) funding specifically provided to your facility for these costs in FY 1988 and projected to be provided for FY 1989.

RESPONSE:

(a) Costs for payment of (1) special salary rates as of June 30, 1988 was $3,749,694.00. Projected cost for special salary rates for the remainder of FY 1988 is $1,511,301.00 and $7,184,516.00 for FY 1989. (2) Unfunded expenses for special drugs and other care for AIDS patients as of June 30, 1988 was $1,800,000.00. Projected cost for the remainder of FY 1988 is $600,000.00, and $2,700,000.00 for FY 1989. There was no unfunded expense for AIDS research as of June 30, 1988, nor any anticipated during the remainder of FY 1988. (3) Educational and training expenses for care and treatment of AIDS patient as of June 30, 1988 was $6,624.00. Projected expenses for the remainder of FY 1988 is $2,371.00 and $25,00.00 for FY 1989. (b) In FY 1988, VAMC-West Los Angeles was provided $1,464,008.00 for special drugs and other care for AIDS patients. Funding provided for AIDS research totaled $676,893.00. Since the 1989 budget has not been received, funding projected to be provided in FY 1989 is unknown.

3. For FY 1988 (as of June 30, 1988), for the remainder of FY 1988, and for FY 1989 the (a) costs of implementing universal precautions as recommended by the Centers for Disease Control in Atlanta, Georgia, and required by the Occupational Safety and Health Administration for the purpose of protecting VA health-care workers against infectious disease , and (b) funding specifically provided to your facility for these costs in FY 1988 and projected to be provided for FY 1989.

RESPONSE:

(a) No costs were incurred for implementing universal precautions as of June 30, 1988. Projected cost for the remainder of FY 1988 is $70,000.00-the implementation cost. Projected estimated expenditures for FY 1989 are $101,500.00 for recurring costs. (b) VAMC-West Los Angeles did not receive funding for costs incurred for implementing universal precautions. Since the 1989 budget has not been received, funding projected to be provided for FY 1989 is unknown.

4. The total amount of funds shifted in FY 1988 (as of June 30, 1988), projected to be shifted for the rest of FY 1988, and projected to be shifted in FY 1989 from all non-recurring accounts, listed separately, to cover current and anticipated operational needs (please describe them).

RESPONSE:

Prior to June 30, 1988, it was necessary to shift $1,783,720.00 to operating supplies and services. Accounts affected were replacement equipment ($699,641.00), additional equipment (426,079.00) and non-recurring maintenance and repair ($658,000.00). Funds were returned to the appropriate accounts during the third quarter after initiation of a program to stay within our funded level. It is projected that $1,582,901.00 will need to be shifted from equipment ($600,000.00) and non-recurring maintenance and repair ($982,901.00) to operating supplies and services in FY 1989.

5. As of September 30, 1987, and June 30, 1988, the total number of beds, broken down by the number of (a) critical care beds, (b) acute medical/ surgical beds, (c) acute psychiatric beds, (d) long-term psychiatric beds, and (e) intermediate and nursing home care beds currently not available for patient admissions. Please break down that data according to the following reasons: (1) staffing shortages due to (A) recruitment difficulties, and (B) lack of funds, (2) lack of other operating funds to support available beds, (3) then current construction or renovation projects, (4) decreased demand for beds. and (5) other reasons (please specify).

RESPONSE:

Beds not available for patient admissions as of September 30, 1987 and June 30 are as follows:

		September 30, 1987	June 30, 1988
(a)	Critical Care	2 - (1)(B) 11 - (1)(A) temporary closure of 7 beds	2 - (1)(B) 10 - (1)(A)
(b)	Acute Medical/ Surgical	62 - (1)(B) 20 - (1)(A) initially then (4) 30 - (1)(A) staffing funds used to open 15 bed AIDS ward 15 - (5) never activated	62 - (1)(B) 35 - (4) 15 - (5) never activated 20 - (5) dialysis to out-patient
(c)	Acute Psychiatric	0	35 - (1)(A)
(d)	Long-term Psychiatric	No long-term beds	
(e)	Intermediate/ Nursing Home	15 - (5) 30 bed ward funded for a 15 bed Palliative Treatment Program	15 - (5) 30 bed ward funded for a 15 bed Palliative Treatment Program
		45 - (1)(A)	64 - (1)(A)
		30 - (4) Staffing funds used to open telemetry unit	30 - (4) Staffing funds used to open telemetry unit
		15 - (5) 30 bed ward funded for 15 bed Palliative Treatment Program	15 - (5) 30 bed ward funded for a 15 bed Palliative Treatment Program
		45 - (1)(A) 30 - (4) Staffing funds used to open Telemetry Unit	64 - (1)(A) 30 - (4) Staffing funds used to open Telemetry Unit.

6. As of January 29, 1988, and June 30, 1988, the median and average waiting times in your facility for non-emergent outpatient appointments in each of the following clinics: general medicine, general surgery, orthopedic, opthamology, cardiology, urology, mental hygiene, and substance abuse.

RESPONSE:

The mean and median waiting times in days (rounded to the nearest day) for non-emergent outpatient clinic appointments as of January 29, 1988 and June 30, 1988 are as follows:

	January 29, 1988		June 30, 1988	
	Mean	Median	Mean	Median
General Medicine	No waiting		No waiting	
General Surgery	7	7	9	10
Orthopedics	23	23	20	20
Opthamology	13	18	17	15
Cardiology	1	2	1	1
Urology	5	5	3	7
Mental Hygiene	8	7	8	7
Substance Abuse	15	14	12	9

7. As of January 29, 1988, and June 30, 1988, the median and average waiting times in your facility for non-emergent inpatient admissions to general medicine, general surgery, orthopedics, urology, acute psychiatry, long-term psychiatry, PTSD in-patient units, substance abuse treatment units, and intermediate and nursing home care beds.

RESPONSE:

There has been no waiting periods for non-emergent inpatient admissions to general medicine, general surgery, orthopedics, acute psychiatry, PTSP or intermediate medicine. The mean and median waiting times (rounded to nearest number) for non-emergent inpatient admissions to other sections as of January 29, 1988 and June 30, 1988 are as follows:

	January 29, 1988		June 30, 1988	
Substance Abuse	5 days	4 days	5 days	4 days
Nursing Home Care Unit				
(Service Connected)	3 months	1 month	3 months	1 month
(Non-Service Connected)	2 1/2 years	2 years	2 1/2 years	2 years

8. As of January 29, 1988, and June 30, 1988, the median and average waiting times for admission for non-emergent cardiac surgery, orthopedic surgeries requiring prostheses, and intraocular lens implants.

RESPONSE:

There were no waiting times for admission for non-emergent cardiac surgery, orthopedic surgeries requiring prosthesis or intraocular lens implants.

9. For FY 1987 and FY 1988 (as of June 30, 1988), if your facility has its own cardiac surgery capability,the number of patients being referred to both VA and non-VA sources for such surgery and the number of such referrals and their average cost.

RESPONSE:

No patients were referred to either VA or Non-VA sources for cardiac surgery.

10. For FY 1987 and FY 1988 (as of June 30, 1988), the mean and median vacancy rates for each of the following personnel categories: psychiatrists, radiologists, anesthesiologists, registered nurses, licensed practical nurses, pharmacists, occupational therapists, physical therapists, and respiratory therapists.

RESPONSE:

Vacancy rates in percentage for FY 1987 and as of June 30, 1988, for requested categories of personnel are as follows:

	FY 1987	FY 1988
Psychiatrists	1.9%	0 %
Radiologists	17.9%	16.0%
Anesthesiologists	8.0%	0%
Registered Nurses	11.0%	14.6%
Licensed Practical Nurses	18.6%	25.4%
Pharmacists	4.7%	9.8%
Occupational Therapists	0%	15.0%
Physical Therapists	20.0%	44.0%
Respiratory Therapists	17.6%	35.0%

11. An estimate of the dollar reductions in inventories for drugs, medical supplies, and prosthetics during FY 1988 (as of June 30, 1988), and the number of times your facility has been depleted of critical items or medications or has experienced critical shortages of these items or medications during FY 1988.

RESPONSE:

There were no dollar reductions in inventories for drugs, medical supplies or prosthetics during FY 1988. Three pieces of equipment were leased due to lack of purchasing funds. A critical shortage of gloves existed from December 1987 through May 1988.

12. The current level of funds available to support contract community nursing home care payments for the balance of FY 1988 and the projected amount that will be available in FY 1989.

RESPONSE:

As of June 30, 1988, there was $1,507,000.00 to support contract Nursing home care payments for the balance of FY 1988. The projected funding for FY 1989 is $5,379,122.00.

13. For FY 1988 (as of June 30, 1988), the rate of surgical postponements and of cancellations due to staff shortages and an estimate of the average delay involved for postponements and what proportion of the postponements involved more than one postponement for a particular veteran.

RESPONSE:

During the period of October 1, 1987 through June 30, 1988, 2,623 major surgical procedures were performed. During this period there were 142 cancellations due to staff shortages. (47 due to lack of supervising surgeons; 95 due to shortage of nurses or anesthesiologists). Records are not maintained on surgical postponements or cancellations prior to being placed on the operating schedule. It could be estimated that the number of postponements would be comparable to the cancellations. In general, the majority of cancellations were rescheduled within 48 hours, although some patients might have experienced a delay of three (3) to four (4) days. It is estimated that the number of veterans having more than one cancellation did not exceed one or two patients per month. These instances were likely elected cases originally scheduled as the last case of the day in a particular operating room.

Sincerely yours,

Rowena Bishop

ROWENA BISHOP, R.N.
Chief of Nursing Service
VAMC-West Los Angeles
Wadsworth Division

Medical Center

Wadsworth and
Brentwood Divisions
Wilshire and
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Los Angeles CA 90073

Veterans
Administration

In Reply Refer To:

September 15, 1988

Honorable Alan Cranston
Chairman, Senate Committee on Veterans' Affairs
United States Senate
Washington, DC

Dear Mr. Chairman:

In response to your request to provide facility comments related to the Chief Medical Director's Task Force Report on Fiscal Year 1989 Budget and the anticipated Fiscal Year 1989 shortfall, the following information is provided:

1. Management officials at VA Medical Center West Los Angeles reviewed the Chief Medical Director's Task Force Report on the Fiscal Year 1989 Budget. The facility supports twelve (12) of the eighteen (18) options (A1-D17) to offset VA Central Office projected Fiscal Year 1989 budget deficits. Exceptions to the options are as follows:

a. A4 Recapture Increased Cost From Target Allowance. Facilities are too far along in their planning to make another major assessment. The medical centers have already had to absorb drastic target allowance cuts and are facing serious budget deficits in Fiscal Year 1989.

b. B5 Reduction in Discretionary Workloads. Adjustments to workload would not be easily quantified into resource savings. Stations negatively impacted by the Resource Allocation Methodology (RAM) are still struggling with identification of workload (earnings) versus cost. These facilities would have difficulty applying cost/FTEE reductions as a function of workload decreases.

c. B7 Non-Recurring Maintenance and Repairs. Continued diversions of non-operating monies into operating accounts may result in repercussions in safety/quality such as serious additional erosion of the Department's plants and facilities.

d. B9 Eliminate Chronic Outpatient Home and Fee Service Dialysis. It would not be possible to maintain required knowledge and skills in performing acute dialysis without an ongoing medical center based outpatient dialysis program.

e. B10 Appeal Congressional Guidance to Maintain Employment at AIDS-Impacted VAMC's. Many of the AIDS impacted VAMC's have been severely cut by previous target allowance reductions (RAM, Productivity and Special Assessments) and to further force budgetary reductions because of AIDS activities would jeopardize needed AIDS programs. The AIDS program by its very nature is a very costly operation and as such has already resulted in a negative impact in the Fiscal Year 1989 Target Allowance (and previous years) because of the RAM process. The intent of Congress is supported.

f. B12 Payment for Prescriptions. If a veteran is accepted for V.A. care, it is felt that the full spectrum of needed treatment should be provided. Requiring a veteran to fully or partially pay for prescription drugs would be of a disservice to veterans and result in hardship for many. The accompanying costs to implement this option may well outweigh the anticipated budgetary savings.

g. C13 Discontinue HCMI and Homeless Domiciliary Programs. Even though the facility supports this option as stated, programs for homeless veterans in the Los Angeles area are critically needed with adequate appropriated funds.

2. Other options that could be considered to offset Fiscal Year 1989 budget shortfalls are:

a. Initiate phasing out of the eight (8) Regional Medical Education Centers (RMECS).

b. Assess District and Regional Offices staffing.

c. Discontinue Systematic External Review Programs (SERP).

d. Consolidate medical facilities such as Veterans Outreach activities with medical centers.

3. Anticipated Budget Shortfalls. After adjusting for reduction of some 115 FTEE caused from RAM, Productivity, cuts and special assessments, VAMC West Los Angeles faces a cost of operations shortfall for Fiscal Year 1989 of $8,463,000.00.

Sincerely yours,

Rowena Bishop

ROWENA BISHOP, R.N.
Chief, Nursing Service
VAMC - West Los Angeles

VETERANS ADMINISTRATION MEDICAL CENTER
BOSTON, MASSACHUSETTS

UNITED STATES SENATE

COMMITTEE ON VETERANS' AFFAIRS

September 9, 1988

In response to Senator Cranston's request dated August 18, 1988, VA Medical Center Boston submits the information contained in Attachment B (thirteen pages). Each page represents one of the thirteen paragraphs, containing multiple questions, from Senator Cranston's letter. Attachment A is a copy of the Senator's letter.

CAROL F. COULTER, R.N.
Chief, Nursing Service

Attachments (2)

PARA. 1. P. 1 COSTS RELATED TO P.L. 100-322

VAMC BOSTON

		FY 88		FY 89	
		COSTS	FUNDING	COSTS	FUNDING
Increases in total reimbursements and administrative costs for beneficiary travel program		$ 11,500 $ 4,500	$ 0 $ 0	$ 45,000 $ 17,500	$ 0 $ 0
	Total	$ 16,000	$ 0	Total $ 62,500	$ 0
R.N. Saturday premium pay		$ 53,317	$ 44,567	$145,912	$ 0
State home per diem increases	(1)	$480,016	$ 0	$ 645,000	$ 0
Outpatient care for those whose care is mandated in the new law		$ 19,665	$ 0	$ 78,660	$ 0

NOTE:

Data below pertains to VAOPC Boston (Court Street clinic), with which BVAMC consolidates effective October 1, 1988:

	FY 88	FY 89
Domiciliary	$391,237	$526,804
Nursing Home	$ 40,622	$ 54,312
Hospital	$ 48,157	$ 64,386

PARA. 2, P. 1 COSTS RELATED TO SPECIAL SALARY RATES & AIDS VAMC BOSTON

		Payment of Special Salary Rates		Unfunded expenses for Special drugs & other AIDS care & research		Educational & training Expenses resulting from Enactment of P.L. 100-322, Related to AIDS care & treatment
FY88 (as of 06/30/88)	Costs:	$1,984,592	Costs:	$318,750	Costs:	$ 7,500
	Funds:	$1,778,559	Funds:	$ 0	Funds:	$ 0
FY88 Projected (07/01/88 - 09/30/88)	Costs:	$ 661,530	Costs:	$106,250	Costs:	$ 2,500
	Funds:	$ 593,000	Funds:	$ 0	Funds:	$ 0
FY89 Projected	Costs:	$2,660,486	Costs:	$489,000	Costs:	$ 11,500
	Funds:	$ 0	Funds:	$ 0	Funds:	$ 0

NOTE:

Special Salary rates at VAOPC Boston:

FY88	Costs:	$141,822
	Funds:	$124,411
FY89	Costs:	$256,459
	Funds:	$124,411

PARA. 3, P. 1 UNIVERSAL PRECAUTIONS VAMC BOSTON

Costs of implementing universal precautions as recommended by the CDC in Atlanta and as required by OSHA for the purpose of protecting VA health-care workers against infectious diseases

	COSTS	FUNDS
FY88 (as of 06/30/88)	$ 93,750	$ 0
FY88 Projected (07/01/31 - 09/30/88)	$ 31,250	$ 0
FY89 Projected	$144,000	$ 0

PARA. 4, P. 2 FUNDS SHIFTED FROM NON-RECURRING VAMC BOSTON

FY88 (as of 06/30/88)	$800,000	(1)
NRM (.23)	$469,284	
Repl. Equip. (.19)	$189,162	
Addl. Equip. (.20)	$141,554	
FY88 (07/01/88 - 09/30/88) Projected	$230,233	
FY89 Projected	$1,348,891	

Anticipated FY89 budget shortage, at our authorized ceiling, which will have to be funded from other resources

NOTE:

(1) $ 800,000 was shifted from Non-Recurring accounts to fund salary shortage
$ 390,000 was shifted from Recurring All Other to fund salary shortage
$ 230,233 projected to be shifted in balance of FY88

$1,420,233 will be shifted in FY88 to fund salary shortages

(2) @ VAOPC Boston, $185,000 was transferred to offset salary shortages:

Repl. Equip. (.19)	$105,000
Addl. Equip. (.20)	$ 80,000

PARA. 5, P. 2 BEDS NOT AVAILABLE FOR PATIENT ADMISSIONS VAMC BOSTON

	BEDS					
	CRITICAL CARE	ACUTE MEDICAL/ SURGICAL	ACUTE PSYCHI- ATRIC	LONG- TERM PSYCHI- ATRIC	INTER- MEDIATE CARE	NURSING HOME CARE
	'87—7 '88—7	'87—303 '88—276	'87—22 '88—22	N/A @ BVAMC	'87—1 '88—1	N/A @ BVAMC
STAFFING SHORTAGES						
Recruitment Difficulties	'87—7 '88—7	'87—155 '88—170	'87—22 '88—22	'87— '88—	'87—1 '88—1	'87— '88—
Lack of Funds	'87—0 '88—0	'87—0 '88—0	'87—0 '88—0	'87— '88—	'87—0 '88—0	'87— '88—
Lack of Other Operating Funds to Support Available Beds	'87—0 '88—0	'87—0 '88—0	'87—0 '88—0	'87— '88—	'87—0 '88—0	'87— '88—
CURRENT CONSTRUCTION OR RENOVATION	'87—0 '88—0	'87—148 '88—106	'87—0 '88—0	'87— '88—	'87—0 '88—0	'87— '88—
DECREASED DEMAND FOR BEDS	'87—0 '88—0	'87—0 '88—0	'87—0 '88—0	'87— '88—	'87—0 '88—0	'87— '88—
OTHER	'87—0 '88—0	'87—0 '88—0	'87—0 '88—0	'87— '88—	'87—0 '88—0	'87— '88—

NOTE:

'87 is as of 09/30/87

'88 is as of 06/30/88

PARA. 6, P. 2 WAITING TIMES FOR NON-EMERGENT OUTPATIENT APPOINTMENTS VAMC BOSTON

	January 29, 188		June 30, 1988	
	MEDIAN	AVERAGE	MEDIAN	AVERAGE
GENERAL MEDICINE	1 day	1 day	1 day	1 day
GENERAL SURGERY	1 week	1 week	1 week	1 week
ORTHOPEDICS	2 weeks	2 weeks	2 weeks	2 weeks
OPHTHALMOLOGY	1 month	1 month	1 month	1 month
CARDIOLOGY	2 weeks	2 weeks	2 weeks	2 weeks
UROLOGY	2 months	2 months	2 months	2 months
MENTAL HYGIENE	1 week	1 week	1 week	1 week
SUBSTANCE ABUSE	1 week	1 week	1 week	1 week

WAITING TIMES FOR NON-EMERGENT ADMISSIONS

	January 29, 1988		June 30, 1988	
	MEDIAN (Days)	AVERAGE	MEDIAN (Days)	AVERAGE
GENERAL MEDICINE	8.42	8.42	8.42	8.42
GENERAL SURGERY	16.47	16.47	16.47	16.47
ORTHOPEDICS	13.54	13.54	13.54	13.54
UROLOGY	7.67	7.67	7.67	7.67
ACUTE PSYCHIATRY	1.40	1.40	1.40	1.40
LONG-TERM PSYCHIATRY	N/A @ BVAMC	N/A @ BVAMC	N/A @ BVAMC	N/A @ BVAMC
PTSD INPATIENT UNIT	N/A @ BVAMC	N/A @ BVAMC	N/A @ BVAMC	N/A @ BVAMC
SUBSTANCE ABUSE TREATMENT UNIT	4.00	4.00	4.00	4.00
INTERMEDIATE CARE BEDS	1.00	1.00	1.00	1.00
NURSING HOME CARE BEDS	N/A @ BVAMC	N/A @ BVAMC	N/A @ BVAMC	N/A @ BVAMC

PARA. 8, P. 2 **WAITING TIMES FOR NON-EMERGENT ADMISSIONS FOR SURGICAL PROCEDURES** **VAMC BOSTON**

	January 29, 1988		June 30, 1988	
	MEDIAN	AVERAGE	MEDIAN	AVERAGE
CARDIAC SURGERY (1)	0	0	0	0
ORTHOPEDIC SURGERY WITH PROSTHESES (2)	3 weeks	3 weeks	3 weeks	3 weeks
INTRAOCULAR LENS IMPLANTS (3)	3-4 wks.	3-4 wks.	3-4 wks.	3-4 wks.

NOTE:

(1) VAMC Boston does not perform cardiac surgery. Veterans are referred to VAMC Brockton/West Roxbury.

(2) Patients wait an average of approximately 2 weeks for an outpatient clinic appointment, from which they are referred for admission for this procedure. They wait approximately 3 weeks for admission and require a 1-week preoperative evaluation (cardiology, anesthesiology, et. al.).

(3) Patients wait an average of approximately 1 month for an outpatient clinic appointment, from which they are referred for admission for this procedure. They wait approximately 3 - 4 weeks for admission and require a 2-day preoperative evaluation.

(4) Other surgical subspecialities, such as ENT, have noted the same delays.

(5) We are sometimes asked to calculate waiting times for outpatient appointments and inpatient admissions using a formula. This calculation can be somewhat skewed, as often the clinicians keep their own waiting lists without informing MAS until the last step in the process. Elective surgery admissions must be scheduled not only in consideration of available beds and nursing staff, but also anesthesiology capacity.

PARA. 9, P. 2 CARDIAC SURGERY VAMC BOSTON

VAMC Boston does not have its own cardiac surgery capability. Veterans are referred to VAMC Brockton/West Roxbury.

NOTE REGARDING REFERRAL DATA:

	No. of Pts. Referred to Other VAMCs	No. of Pts. Referred to Non-VA Care	Cost per Non-VA Referral
FY87	70	1	$21,393
FY88	49	0	0

PARA. 10, P. 2 VACANCY RATES VAMC BOSTON

	FY87		FY88 (06/30/88)	
	MEAN	MEDIAN	MEAN	MEDIAN
Psychiatrists	8 %	8 %	13 %	13 %
Radiologists	0 %	0 %	20 %	20 %
Anesthesiologists	40 %	40 %	40 %	40 %
Registered Nurses	13 %	13 %	20 %	20 %
Licensed Practical Nurses	44 %	44 %	61 %	61 %
Pharmacists	0 %	0 %	0 %	0 %
Occupational Therapists	29 %	29 %	36 %	36 %
Physical Therapists	39 %	39 %	23 %	23 %
Respiratory Therapists	41 %	41 %	35 %	35 %

PARA. 11, P. 3 REDUCTION IN INVENTORIES VAMC BOSTON

	FY88 (06/30/88)	NUMBER OF TIMES DEPLETED	NUMBER OF TIMES OF CRITICAL SHORTAGE
DRUGS	$ 0	0	0
MEDICAL SUPPLIES	$ 0	0	0
PROSTHETICS	$ 0	0	0

NOTE:

(1) Data below applies to VAOPC Boston:

	FY88 (06/30/88)	NUMBER OF TIMES DEPLETED	NUMBER OF TIMES OF CRITICAL SHORTAGE
DRUGS	$593,012	0	0
MEDICAL SUPPLIES	$472,192	0	0
PROSTHETICS	$ 65,000	0	0

PARA. 12, P. 3 CONTRACT COMMUNITY NURSING HOME CARE VAMC BOSTON

	FUNDS
FY88 Current level (remainder of year)	$ 140,161
FY89 Projected	$2,679,477

PARA. 13, P. 3 SURGICAL POSTPONEMENTS OF NON-EMERGENT CASES RELATED TO STAFF SHORTAGES VAMC BOSTON

	FY88 (06/30/88)
POSTPONEMENTS	44
CANCELLATIONS	0
AVERAGE DELAY FOR POSTPONEMENTS	1 - 2 DAYS; Case is done on next operating day
PROPORTION OF POSTPONEMENTS WITH MORE THAN 1 POSTPONEMENT FOR A PARTICULAR VETERAN	0

NOTE:

On any given day, approximately 1/3 of the patients currently in-house who are ready for surgery are not booked due to the acuity of our anesthesiology staffing shortage (physicians & nurse anesthetists).

Veterans
Administration

United States Senate Committee on Veterans Affairs Testimony

September 9, 1988

Brooklyn Veterans Administration Medical Center
800 Poly Place
Brooklyn, NY 11209

James J. Farsetta, Director

Veterans Administration
Medical Center Brooklyn, New York

1. (a) Projected costs for the remainder of FY88 and FY89 resulting from the enactment of P.L.100-322:

	(Beneficiary Travel) Increases In Total Reimbursements	(Beneficiary Travel) Increases In Total Administrative Costs	(Annual Total) Increases In Total Reimbursements	(Annual Total) Increases In Total Administrative Costs	RN Saturday Premium Pay	State Home Per Diem Increases	OPT Care
(1) Remainder							
FY88	$165,000	0	$165,000	0	$198,000	N/A	$250,000
FY89	$300,000	0	$300,000	0	$286,000	N/A	$1,000,000
(b). Funding provided							
FY88	$165,000	0	$165,000	0	$87,000	N/A	0
Projected FY89	0	0	0	0	0	N/A	0

Veterans Administration
Medical Center Brooklyn, New York

2. (a) Costs For The Payment Of:

	Special Salary Rates	Unfunded Expenses For Special Drugs And Other Care For AIDS Paitients And For AIDS Research	Educational/Training Expenses Related To The Care And Treatment Of AIDS Patients
Current FY88	$4,398,629	$3,331,485	$4,500
Projected Remainder FY88	$1,884,097	$1,110,494	$1,500
Projected FY89	$7,444,788	$6,185,115	$20,000
(b). Funding provided:			
FY88	$4,222,745	$863,787	0
Projected FY89	$5,240,762	0	0

Veterans Administration
Medical Center Brooklyn, New York

3. (a) Costs of Implementing Universal Precautions for the Purpose of Protecting VA Health - Care Workers Against Infectious Diseases:

FY88 (as of 6/30/88)	FY88 (remainder)	FY89
$163,219	$54,406	$230,683

3. (b) Funding Specifically Provided For These Costs:

FY88	Projected FY89
0	0

Veterans Administration
Medical Center Brooklyn, New York

4. Funds Shifted

FY88 (as of June 30, 1988) = 0

Projected For Rest Of FY88 = 0

FY89 - $600,000*

* From equipment

Veterans Administration
Medical Center Brooklyn, New York

5. Beds Not Available:

	Staffing Shortages		Lack of Other Operating Funds to Support Available Beds	Current Construction or Renovation Projects	Decreased Demands for Beds	Other Reasons
	Recruitment Difficulties	Lack of Funds				
Critical Care Beds	0	0	0	0	0	0
Acute Medical/Surgical Beds	40	0	0	87	91	68*
Acute Psychiatric Beds	0	0	0	14	0	0
Long-Term Psychiatric Beds	0	0	0	0	0	0
Intermediate and Nursing Home Care Beds	0	0	0	0	0	0
Total	40	0	0	101	91	68*

TOTAL: 300

* Space being used for office, temporary storage and outpatient clinic
(Note: figures have remained the same from September 30, 1987 to June 30, 1988)

Veterans Administration
Medical Center Brooklyn, New York

6. Average Waiting Time for Non-Emergent Outpatient Appointments In Each of the Following Clinics:

General Medicine -	5 days
General Surgery -	5 days
Orthopedics -	40 days
Ophthalmology -	40 days
Cardiology -	80 days
Urology -	20 days
Mental Hygiene -	75 days
Substance Abuse -	30 days

Veterans Administration
Medical Center Brooklyn, New York

7. Average Waiting Time for Non-Emergent Inpatient Admissions for the Following Clinics:

General Medicine -	10 days
General Surgery -	10days
Orthopedics -	8 days
Urology -	9 days
Acute Psychiatry -	0
Long Term Psychiatry -	N/A
PTSD -	0
Substance Abuse -	25 days
Intermediate Care -	15 days
Nursing Home Care (Service Connected) -	120 days
Nursing Home Care (Non-Service Connected) -	Bed not available

Veterans Administration
Medical Center Brooklyn, New York

8. Average Waiting Time for Admission for the Following :

Non-emergent cardiac surgery -	45 days
Orthopedic -	13 days
Intraocular lens implants -	10 days

Veterans Administration
Medical Center Brooklyn, New York

9. Number of Cardiac Surgery Referrals:

	# To Other VA's	# To Non-VA's	Cost/Non-VA Referral
FY87	43	0	Not Available
FY88	59	0	Not Available

Veterans Administration
Medical Center Brooklyn, New York

10. Mean Vacancy Rates for the Following Categories:

Category	Rate FY87	Rate FY88
Psychiatrists	20%	35%
Radiologists	16%	18%
Anesthesiologists	0%	0%
Registered Nurses	7%	6%
Licensed Practical Nurses	8%	0%
Pharmacists	24%	19%
Occupational Therapists	50%	58%
Physical Therapists	75%	88%
Respiratory Therapists	24%	24%

Veterans Administration
Medical Center Brooklyn, New York

11. Estimate of Dollar Reductions in Inventories for the Following (FY88):

	Reduction in Dollars	Number of Times Depletion or Critical Shortages Were Experienced
Drugs	$500,000	Multiple times
Medical Supplies	$500,000	Multiple times
Prosthetics	$35,000	Multiple times

Veterans Administration
Medical Center Brooklyn, New York

12. The Current Level of Funds Available to Support Contract Community Nursing Home Care Payments For:

The Balance of FY88	$757,172
The Projected Amount for FY89	$3,030,274

Veterans Administration
Medical Center Brooklyn, New York

13. The Rate of Surgical Postponements and of Cancellations Due to Staff Shortages:

Rate of Postponements -	4%
Rate of Cancellations -	35%

Average delay involved for postponements - 3 days

Proportion of postponements which involved more than one postponement for a particular veteran - 0

Veterans
Administration

In Reply Refer To:

September 16, 1988

Honorable Alan Cranston
Member, United States Senate
Chairman, Committee on Veterans' Affairs
Washington, D.C. 20510-6375

Dear Senator Cranston:

Pursuant to your letter of September 12, 1988, enclosed are comments to the questions on VA health care. This document was developed as a result of my role as Chairman of the Region 1 Planning Board. The comments included represent the opinions of VAMC Directors throughout the Northeast Region.

If I can be of any further assistance, please do not hesitate to contact me at (718) 630-3521.

Sincerely,

James J. Farsetta

JAMES J. FARSETTA
Director

Immediate and decisive action is necessary if DM&S is to avoid violation of the Anti-deficiency Act in FY 1989. Unless funds can be captured now to remedy operational shortfalls, many VA Medical Centers will have insufficient money to operate next fiscal year. In addition, a long range solution is need to meet continued fiscal constraints.

The Executive Summary is a strategic plan which was initiated by first using a nominal group process similar to the process used at the RAM Consensus Conference. This took place at the Regional Budget hearings with VAMC Directors and Chiefs of Staff participating. The Region Planning Board then deliberated for two days to further develop this strategy. Specific implementable plans and protocols can be made available upon request.

This paper contains both a short range emergency "stopgap" strategy to address unprecedented budget deficits in FY 1989 and a long range strategic solution for FY 1990 and beyond. The stopgap measures for FY 1989 will not be effective without agency commitment to also implement a long range strategy for facility closure, consolidation and mission change.

The recommended FY 1989 stopgap strategy would include such actions as the elimination of beneficiary travel, not implementing discretionary portions of Public Law 100-322, and a one year moratorium on all major, minor and minor miscellaneous construction projects with the diversion of these monies to operating funds. This will provide the Departrment with the necessary funds to "buy time" for DM&S to implement a national long term strategy.

The long range strategy includes the closure, realignment or mission change of a number of medical centers beginning in FY 1990, coupled with a revised system for resource allocation. Resources would be distributed to the Region based on a capitation methodology then distributed within the Region using the RAM and appropriateness of care protocols. This would reduce the level of inappropriate admissions experienced at several RAM gainer facilities, and would reduce the incentives for growth that have been diverting resources from core patient care programs to lower priority activities.

Short-range strategies for maintaining the integrity of VA Medical Centers are listed below in priority order. It is anticipated that these measures will provide enough funding to allow DM&S to position itself to initiate the appropriate phasing of mission changes and facility closures. Actions were selected on their ability to produce funds that could immediately be diverted for operational use. Some actions require legislative authority. Medical Center Directors would be delegated maximum flexibility to implement these changes.

1. Eliminate Beneficiary Travel
2. Eliminate Activations funding
3. Do not implement discretionary portions of PL 100-322
4. Diversion of Major, Minor, Minor Miscellaneous Construction funds to patient care for 1 year (In effect, a 1 year moratorium)
5. Install capitation funding system to fund Region and use RAM coupled with appropriateness of care protocols for distribution within regions
6. Do not fund Shared High Tech Equipment
7. No new Satellite Outpatient Clinics
8. Eliminate funding for FY 1989-MEDIPP initiatives
9. Drop prescription drugs for category B&C outpatients
10. Reduce non VA Workload 10%
11. Adjust FTEE Floor
12. Decentralize and Reprogram Community Nursing Home Funds
13. Eliminate care for category B&C veterans
14. Drop prescription drugs for all outpatient care

Rational for most of the above recommendations are already contained in the Field Advisory Council papers and are not duplicated here. Exceptions are:

CONSTRUCTION: The Regional Planning Board recommended a moratorium on Major, Minor and Minor Miscellaneous construction nationwide. The funds would be used to cover part of the FY 1989 shortfall and buy time until long term changes could be implemented. While this alternative is not very desirable in light of the considerable construction needs of DM&S, it would allow for a significant amount of money to be reprogramed in the short term to meet higher priority patient care needs. It is recognized that Congressional approval would be required for this alternative.

ACTIVATIONS: Eliminate activation funding. We are funding programs that we cannot afford at the expense of core services at every VAMC, e.g., at one VAMC FTEE increased by 400 after construction without a corresponding increase in workload. The 400 FTEE came effectively from a tax on all VA Medical Centers. Most VAMCs with major activations in the past few years have become RAM losers.

RESOURCE ALLOCATION: Initiate capitation system for distributing funds to Regions, and use RAM coupled with appropriateness of care protocols for resource distribution within the Region.

Hospitals that practice good utilization management by admitting only patients whose illness demands acute care intervention are chronically underpaid, while hospitals that admit patients unnecessarily reap windfall profits. Preliminary analysis of data collected by VA researchers at Bedford and Iowa City confirm that the VA prospective payment system is perversely rewarding inefficiency.

The system needs to give VAMC Directors the flexibility to reduce workload without adversely impacting the future of their VAMC. We need to do away with incentives for growth that divert monies from essential core programs to fund low priority workloads. Between FY 86 and FY 87 unique outpatients increased by 2.7 percent nationally. In one Region, this increase was 9.6 percent. While it is unlikely this increase was entirely RAM inspired, it was surely in part responsible. This practice must be contained.

A strategic change in Resource Allocation Methodology is needed if these problems are to be resolved. At a recent meeting of Regional Directors and the DACMD for Operations, it was agreed that a capitation-like distribution should be explored. This methodology would be used to determine funding among Regions. It potentially could eliminate or reduce the problems described above.

PERSONNEL SERVICES FLOOR: The VA can no longer support in excess of 194,000 FTEE at the expense of all other costs. VAMC Directors must have the flexibility to set their employment at the level that best matches their funding and assigned mission. This flexibility would improve our capability to deliver cost efficient patient care.

NURSING HOME CARE: The Community Nursing Home (CNH) accounts should be decentralized to the VAMC level and Directors should have flexibility to either:

1. Increase VA NHCU census by placing CNH patients in vacant VAMC beds by using CNH money.

2. Close VA NHCU beds, placing those patients in CNH beds.

This option wold allow the VA to treat patients in the most cost efficient manner, i.e., use which ever bed is least costly. An alternative action would be to reduce CNH contracts to 2 months and reprogram two thirds of CNH dollars.

Long Term Strategy FY 90 and Beyond

The long range strategy for implementing the anticipated fiscal shortfalls in future years includes closing, consolidating or altering the missions of several medical centers to provide more appropriate levels of care to a changing veteran population and to allow for a redistribution of available healthcare resources consistent with those changing needs. A revised resource allocation methodology based on capitation to the Region and appropriateness of care protocols is crucial to ensuring the equitable redistribution of funds.

Vertical cuts are necessary because we can no longer make across the board (horizontal) cuts and still provide quality care. Vertical cuts are appropriate because veteran population and LOS are declining, and alternatives to inpatient care are becoming more available. Consistent with our shift from inpatient to outpatient care and our increasing need for long term care, we no longer need all of the acute care capacity we have.

In order to further develop this long term strategy, the DM&S must publicly state that we do not have the money to continue the current level of services. At that time we can begin an in-depth mission review with involved VAMC management, affiliations and constituents to assure that adverse impacts are minimized. The Regional Planning Board felt that a few large adjustments to the system would be politically more expedient than several small cuts, and that the end result would be a more efficient health care delivery system.

Region One Recommends The Following As a Long Term Strategy

1. Mission Change, Consolidation or Closure of several VAMCs
2. Improve utilization of VA facilities by applying appropriateness of care protocol coupled with revised resource allocation.

INFORMATION REQUESTED FOR THE SEPTEMBER 9, 1988, SENATE VETERANS AFFAIRS COMMITTEE HEARINGS
VA MEDICAL CENTER, BOISE, IDAHO

1. THE PROJECTED:

A. COSTS FOR THE REMAINDER OF FY 1988 AND FY 1989 RESULTING FROM THE ENACTMENT OF PUBLIC LAW 100-322 FOR

	FY88	FY89
1. THE INCREASES IN TOTAL REIMBURSEMENTS AND ADMINISTRATIVE COSTS FOR THE BENEFICIARY TRAVEL PROGRAM	$11,700	$76,000
(AND THE ANNUAL TOTALS OF EACH).	$310,000	$400,000
2. REGISTERED NURSE SATURDAY PREMIUM PAY	$25,000	$70,200
3. STATE HOME PER DIEM INCREASES	$97,500	$137,000
4. OUTPATIENT CARE FOR THOSE FOR WHOM CARE WAS MANDATED IN THE NEW LAW.	$115,000*	$480,000

*INCREASES IN COSTS FOR OUTPATIENT CARE FOR VETERANS MANDATED UNDER PL 100-322 IMPACTS APPROXIMATELY 8% OF OUR OUTPATIENT WORKLOAD.

B. FUNDING SPECIFICALLY PROVIDED TO YOUR FACILITY FOR THESE COSTS IN FY 1988 AND PROJECTED TO BE PROVIDED FOR FY 1989.

	FY88	FY89
BENEFICIARY TRAVEL PUBLIC LAW FUNDING	$11,774	-0-
BENEFICIARY TRAVEL TOTAL FUNDING	$201,270	$189,496
REGISTERED NURSE SATURDAY PREMIUM PAY	$19,553	-0-
STATE HOME PER DIEM INCREASE	$97,556	$137,058
OUTPATIENT CARE	$11,657	-0-

2. THE CURRENT FY 1988 (AS OF JUNE 30, 1988) AND PROJECTED REMAINDER OF FY 1988 AND ALL OF FY 1989.

A. COSTS FOR THE PAYMENT OF:	6/30/88	7/1-9/30	FY89
1. SPECIAL SALARY RATES	$10,270	$23,456	$153,490
2. UNFUNDED EXPENSES FOR SPECIAL DRUGS AND OTHER CARE FOR AIDS PATIENTS AND FOR AIDS RESEARCH	-0-	-0-	$40,000*
3. EDUCATIONAL AND TRAINING EXPENSES RESULTING FROM THE ENACTMENT OF PUBLIC LAW 100-322, RELATING TO THE CARE & TREATMENT OF AIDS PATIENTS	$700	$800	$3,000

*BOISE HAS EXPERIENCED RELATIVELY MINOR AIDS IMPACT. THE FY89 ESTIMATE IS BASED ON THE ASSUMPTION THAT THERE WILL BE ONE AIDS PATIENT FOR THE YEAR.

INFORMATION REQUESTED FOR THE SEPTEMBER 9, 1988, SENATE VETERANS AFFAIRS COMMITTEE HEARINGS
VA MEDICAL CENTER, BOISE, IDAHO

B. FUNDING SPECIFICALLY PROVIDED TO YOUR FACILITY FOR THESE COSTS IN FY 1988 AND PROJECTED TO BE PROVIDED FOR FY 1989.

	FY88	FY89
SPECIAL SALARY RATES	$47,250*	$153,490
AIDS TREATMENT AND RESEARCH	-0-	-0-
AIDS EDUCATION AND TRAINING	-0-	-0-

*THE DISPARITY BETWEEN FUNDING AND COST IS CAUSED BY THE INABILITY TO RECRUIT QUALIFIED CANDIDATES IN SPITE OF SPECIAL PAY RATES.

3. FOR FY 1988 (AS OF JUNE 30, 1988), FOR THE REMAINDER OF FY 1988, AND FOR FY 1989

	6/30/88	7/1-9/30	FY89
A. COSTS OF IMPLEMENTING UNIVERSAL PRECAUTIONS AS RECOMMENDED BY THE CENTERS FOR DISEASE CONTROL IN ATLANTA, GEORGIA AND REQUIRED BY THE OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION FOR THE PURPOSE OF PROTECTING VA HEALTH-CARE WORKERS AGAINST INFECTIOUS DISEASES.	$4,000	$8,000	$100,000*
B. FUNDING SPECIFICALLY PROVIDED TO YOUR FACILITY FOR THESE COSTS IN FY 1988 AND PROJECTED TO BE PROVIDED FOR FY 1989.		-0-	-0-

*THIS DOES NOT INCLUDE THE POTENTIAL $45,000 COST OF ASH DISPOSAL IF THE COUNTY/CITY GOVERNMENTS IN CONJUNCTION WITH THE EPA DETERMINES THAT MEDICAL CENTER ASH IS A HAZARDOUS SUBSTANCE AND REQUIRES DISPOSAL IN A HAZARDOUS MATERIAL DUMP.

CONSIDERATION SHOULD ALSO BE GIVEN TO THE AMOUNT OF STAFF TIME REQUIRED IN IMPLEMENTING THE NEW UNIVERSAL PRECAUTIONS. WHILE OUR DATA IS NOT COMPLETE IT IS ESTIMATED AS MUCH AS 5% OF STAFF PRODUCTIVITY COULD BE LOST.

4. THE TOTAL AMOUNT OF FUNDS SHIFTED IN FY 1988 (AS OF JUNE 30, 1988), PROJECTED TO BE SHIFTED FOR THE REST OF FY 1988, AND PROJECTED TO SHIFTED IN FY 1989 FROM ALL NON-RECURRING ACCOUNTS, LISTED SEPARATELY, TO COVER CURRENT AND ANTICIPATED OPERATIONAL NEEDS (PLEASE DESCRIBE THEM).

	6/30/88	7/1-9/30	FY89
.19 REPLACEMENT EQUIPMENT	$60,000	$7,628	$50,000
.20 ADDITIONAL EQUIPMENT	-0-	$6,644	$20,000
.21 CONTRACT HOSPITALIZATION	$30,000	$54,435	$133,000*
.22 STATE HOMES	-0-	$62,533	-0-
.23 NON RECURRING M&R	$100,000	$3,805	-0-
.24 COMMUNITY NURSING HOME CARE	$60,000	$40,880	$602,000**
.27 FEE MEDICAL	$10,000	$84,633	$175,000
.28 FEE DENTAL	$45,000	$(1,830)	$47,000
TOTAL	$355,000	$258,728	$1,027,000

INFORMATION REQUESTED FOR THE SEPTEMBER 9, 1988,
SENATE VETERANS AFFAIRS COMMITTEE HEARINGS
VA MEDICAL CENTER, BOISE IDAHO

4. (CONTINUED)

*$133,000 WILL BE RECOUPED IF FUNDING IS RESTORED TO FY 1988 LEVELS.

**$602,000 WOULD BE AVAILABLE TO TRANSFER IF WE ONLY PROVIDE NURSING HOME CARE TO SERVICE CONNECTED VETERANS FOR THEIR SERVICE CONNECTED CONDITIONS.

5. AS OF SEPTEMBER 30. 1987, AND JUNE 30, 1988, THE TOTAL NUMBER OF BEDS, NOT AVAILABLE FOR PATIENT ADMISSIONS:

	9/30/87	6/30/88
A. CRITICAL CARE BEDS	-0-	-0-
B. ACUTE MEDICAL/SURGICAL BEDS	43	43*
C. ACUTE PSYCHIATRIC BEDS	-0-	-0-
D. LONG-TERM PSYCHIATRIC BEDS	-0-	-0-
E. INTERMEDIATE AND NURSING HOME CARE BEDS	-0-	-0-

*ON JUNE 30, 1988, WE HAD 43 BEDS OUT OF SERVICE DUE TO OUR GEOTHERMAL CONVERSION PROJECT. THIS PROJECT SHOULD BE COMPLETED ABOUT OCTOBER, 15, 1988. 25 BEDS WILL REMAIN CLOSED AFTER THE PROJECT DUE TO DECREASING CENSUS AND LENGTHS OF STAY. THIS SPACE WILL BE USED FOR EXPANDED CLINIC OPERATIONS TO ABSORB INCREASING OUTPATIENT WORKLOAD.

6. AS OF JANUARY 29, 1988 AND JUNE 30, 1988, THE AVERAGE WAITING TIMES IN YOUR FACILITY FOR NON-EMERGENT OUTPATIENT APPOINTMENTS IN EACH OF THE FOLLOWING CLINICS:

	1/29/88	6/30/88
GENERAL MEDICINE	3.5 MONTHS	3.5 MONTHS
GENERAL SURGERY	2 MONTHS	1 MONTH
ORTHOPEDIC	3 MONTHS	4 MONTHS*
OPTHAMOLOGY	3 MONTHS	3 MONTHS*
CARDIOLOGY	2 MONTHS	2 MONTHS*
UROLOGY	2 WEEKS	1.5 MONTHS
MENTAL HYGIENE	1 MONTH	2 MONTHS
SUBSTANCE ABUSE	1 WEEK	1 WEEK

*ORTHOPEDIC, OPTHAMOLOGY, AND CARDIOLOGY CLINICS ARE BEING RESTRICTED TO SERVICE CONNECTED AND CATEGORY "A" VETERANS.

INFORMATION REQUESTED FOR THE SEPTEMBER 9, 1988,
SENATE VETERANS AFFAIRS COMMITTEE HEARINGS
VA MEDICAL CENTER, BOISE, IDAHO

7. AS OF JANUARY 29, 1988, AND JUNE 30, 1988, THE AVERAGE WAITING TIMES IN YOUR FACILITY FOR NON-EMERGENT INPATIENT ADMISSIONS TO:

	1/29/88	6/30/88
GENERAL MEDICINE	NO WAIT	NO WAIT
GENERAL SURGERY	2-3 WEEKS	NO WAIT
ORTHOPEDICS	DUE TO STAFFING SHORTAGES, REFERRING TO OTHER VA'S	ELECTIVE CASES* DEFERRED UNTIL 10/1/88
UROLOGY	NO- WAIT	NO WAIT
ACUTE PSYCHIATRY	NO WAIT	NO WAIT
LONG-TERM PSYCHIATRY	**	**
PTSD IN-PATIENT UNITS	**	**
SUBSTANCE ABUSE TREATMENT UNITS	NO WAIT	NO WAIT
INTERMEDIATE AND NURSING HOME CARE BEDS	4-6 WEEKS	4-6 WEEKS

*ORTHOPEDIC SURGERIES FOR TOTAL JOINTS RESTRICTED TO 50% OR MORE SERVICE CONNECTED OR SERVICE CONNECTED FOR THE CONDITION BEING TREATED.

**PATIENTS REQUIRING CARE IN BOTH LONG-TERM PSYCHIATRY AND PTSD IN-PATIENT UNITS HAVE HISTORICALLY BEEN PLACED IN OTHER VA FACILITIES. THE PRESENT ECONOMIC CONDITIONS HAVE MADE PLACEMENT DIFFICULT, WITH EACH FACILITY TRYING TO MAINTAIN ADEQUATE HEALTH CARE FOR THEIR OWN CATCHMENT AREA.

8. AS OF JANUARY 29, 1988, AND JUNE 30, 1988, THE AVERAGE WAITING TIMES FOR ADMISSION FOR NON-EMERGENT

	1/29/88	6/30/88
CARDIAC SURGERY	**	**
ORTHOPEDIC SURGERIES REQUIRING PROSTHESES	REFERRAL TO OTHER VA'S	DEFERRED TO* 10/1/88
INTEROCULAR LENS IMPLANTS	**	**

*ORTHOPEDIC SURGERIES FOR TOTAL JOINTS, INCLUDING TOTAL HIP AND KNEE REPLACEMENT ARE RESTRICTED TO 50% OR MORE SERVICE CONNECTED OR SERVICE CONNECTED FOR THE CONDITION BEING TREATED.

**CARDIAC SURGERIES AND INTEROCULAR LENS IMPLANTS HAVE HISTORICALLY BEEN REFERRED TO OTHER VA MEDICAL CENTERS. BECAUSE OF BUDGET CONSTRAINTS, REFERRALS HAVE BECOME MORE DIFFICULT WITH EITHER LONG DELAYS OR RELUCTANCE TO ACCEPT THE PATIENT.

INFORMATION REQUESTED FOR THE SEPTEMBER 9, 1988, SENATE VETERAN AFFAIRS COMMITTEE HEARING
VA MEDICAL CENTER, BOISE, IDAHO

9. FOR FY 1987 AND FY 1988 (AS OF JUNE 30, 1988), IF YOUR FACILITY HAS ITS OWN CARDIAC SURGERY CAPABILITY

*SEE QUESTION NUMBER 8

10. FOR FY 1987 AND FY 1988 (AS OF JUNE 30, 1988), THE AVERAGE VACANCY RATES FOR EACH OF THE FOLLOWING PERSONNEL CATEGORIES

	6/30/87	6/30/88
PSYCHIATRISTS	-0-	-0-
RADIOLOGISTS	-0-	1*
ANESTHESIOLOGISTS	2	-0-
REGISTERED NURSES	16	21*
LICENSED PRACTICAL NURSES	4	4*
PHARMACISTS	2	1*
OCCUPATIONAL THERAPISTS	1	1*
PHYSICAL THERAPISTS	1	2*
RESPIRATORY THERAPISTS	1	-0-

*WHILE ALL OF THESE POSITIONS ARE BEING ACTIVELY RECRUITED IT IS UNLIKELY THEY COULD ALL BE FILLED DUE TO INADEQUATE FUNDING.

11. AN ESTIMATE OF THE DOLLAR REDUCTIONS IN INVENTORIES FOR

DRUGS	$335,559
MEDICAL SUPPLIES	$112,568
PROSTHETICS	$41,873
TOTAL	$490,000

THE NUMBER OF TIMES YOUR FACILITY HAS BEEN DEPLETED OF CRITICAL ITEMS OR MEDICATIONS OR HAS EXPERIENCED CRITICAL SHORTAGES OF THESE ITEMS OR MEDICATIONS DURING FY 1988. (22 TIMES)

	FY88	FY89
12. THE CURRENT LEVEL OF FUNDS AVAILABLE TO SUPPORT CONTRACT COMMUNITY NURSING HOME CARE PAYMENTS FOR THE BALANCE OF FY 1988 AND THE PROJECTED AMOUNT THAT WILL BE AVAILABLE IN FY 1989.	$678,780	$796,897

13. FOR FY 1988 (AS OF JUNE 30, 1988), THE RATE OF SURGICAL POSTPONEMENTS AND OR CANCELLATIONS DUE TO STAFF SHORTAGES AND AN ESTIMATE OF THE AVERAGE DELAY INVOLVED FOR POSTPONEMENTS AND WHAT PROPORTION OF THE POSTPONEMENTS INVOLVED MORE THAN ONE POSTPONEMENT FOR A PARTICULAR VETERAN.

AS OF JUNE 30, 1988 SURGICAL POSTPONEMENTS AVERAGED 9 A MONTH.

THE AVERAGE DELAY WAS 3 TO 5 DAYS.

ON AVERAGE, ONE PATIENT A MONTH WAS POSTPONED MORE THAN ONCE.

MEPP (SMART PROGRAM)

9/2/88 SUMMARY

BOISE

MEPP, RENAMED SMART, IS AN INNOVATIVE 3-YEAR TEST DESIGNED TO IMPROVE MANAGEMENT EFFICIENCY AND EFFECTIVENESS BY SELECTIVELY REMOVING LEGAL AND ADMINISTRATIVE IMPEDIMENTS AT 11 FIELD STATIONS; 5 MEDICAL CENTERS, 5 REGIONAL OFFICES, AND 1 DATA PROCESSING CENTER. THIS PROGRAM GIVES BOISE MORE FLEXIBILITY TO IMPROVE MANAGEMENT PRACTICES BY RECEIVING WAIVERS OF PROCEDURES.

WAIVER REQUESTS ARE GENERATED BY EMPLOYEES AND APPROVED/DISAPPROVED BY VA CENTRAL OFFICE OFFICIALS OR BY LOCAL MANAGEMENT, IF NO AGENCY PROCREDURE IS INVOLVED.

WAIVERS SUBMITTED: (EXCLUDES INITIAL VACO INITIATED WAIVERS)

TO VACO
845 TOTAL
203 DM&S - 84 GRANTED OR CONDITIONALLY GRANTED
66 BOISE - 32 GRANTED OR CONDITIONALLY GRANTED
TOTAL GENERATED AT BOISE 163
TOTAL IMPLEMENTED AT BOISE 49 + 26 FROM OTHER FACILITIES

EVALUATION:

VACO - SITE VISITS
ORGANIZATIONAL CLIMATE SURVEY
WAIVER SPECIFIC
CONTROL GROUPS

BOISE - ORGANIZATIONAL CLIMATE SURVEY
WAIVER SPECIFIC (CRITERION BASED)
ANECDOTAL

PROGRAM AWARENESS/AWARDS:

RENAME PROGRAM (SMART) START MAKING ALTERNATIVES A REALITY TODAY

SMART $ WITH EINSTEIN'S PICTURE ($25.00 IMPACT AWARDS) 8 TO DATE

"THIS IDEA SEEMS DUMB TO ME" 119 RECEIVED TO DATE 18 ADOPTED

IDEAS ROUTED THROUGH INCENTIVE AWARDS/SUGGESTION PROGRAM

2 HRS LEAVE - 106 GRANTED TO DATE

UPDATES IN THE PERSONNEL NEWSLETTER

SMART BULLETIN BOARD

KEYCHAINS FOR "GOOD SERVICE" 25 EACH MONTH (BEING IMPLEMENTED)

"SMART" BUTTONS - ONE TO ANYONE WHO SUBMITS IDEA/SUGGESTION

MAJOR ACCOMPLISHMENTS:

PRIME VENDOR - IN PROGRESS (PHARMACY)

REPORTS 18 ELIMINATED OR NOT REQUIRED WHEN NEGATIVE

ABILITY TO MOVE $ BETWEEN ACCOUNTS

USE OF BEDS - REALLOCATION/OPEN OR CLOSE

4TH QUARTER SPENDING RESTRICTIONS REMOVED

EMPLOYEE MORALE INCREASED - THEY FEEL THEY CAN MAKE A DIFFERENCE

```
SMART TRACKING LIST                                SEP  2,1988  15:01    PAGE 1
        WAIVER EXPLANATION
            VACO ACTION
-------------------------------------------------------------------------------

      CURRENT STATUS: C.O. ACTION PENDING


 WAIVER:  REQUEST THE ABILITY TO GRANT PARTIAL APPROVAL FOR PCS TYPE MOVES.
          UNDER THE CURRENT LAW IF ANY PORTION OF PCS TRAVEL IS APPROVED ALL
          PORTIONS ARE APPROVED.

 VACO ACTION:  C.O. AGREES.  CURRENTLY PENDING C.O. REQUESTING GSA APPROVAL.


 WAIVER:  RAISE THE REQUIREMENT FOR REPORTING ON VA FORM 07-2268 OR 90-2268
          FROM $2,500 TO $10,000 FOR INITIAL NON-SET-ASIDES WHEN PROCUREMENT
          ACTION WILL BE A SOLE SOURCE SINCE FAR 6.303 AND 304 REQUIRES
          JUSTIFICATION AND APPROVAL FOR MAKING A SOLE SOURCE PROCUREMENT.
          WILL REDUCE PAPERWORK.

 VACO ACTION:  C.O. AGREES - WAIT FOR VAAR CHANGE


 WAIVER:  ELIMINATE NEED FOR SF 46, GOV'T DRIVER'S LICENSE.  CURRENT STATE
          LICENSE SHOULD BE SUFFICIENT.

 VACO ACTION:  C.O. AGREES. PENDING C.0. REQUEST FOR GSA APPROVAL. IS LISTED
               UNDER THE WINSTON, SALEM CONTROL NUMBER 98.


 WAIVER:  WAIVE 1 YEAR SPECIALIZED EXPERIENCE REQUIREMENT FOR GS 7 CAREER
          INTERN QUALIFICATIONS.

 VACO ACTION:  AGENCY APPROVES, BUT NEEDS OPM APPROVAL.


 WAIVER:  ALLOW LOCAL FACILITIES TO NEGOTIATE WITH LOCAL TRAVEL AGENCIES TO
          ASSURE LOWEST BID, BEST PRICES FOR EMPLOYEE TRAVEL.

 VACO ACTION:  GRANTED, BUT NEED GSA APPROVAL PRIOR TO IMPLEMENTATION.


 WAIVER:  ALLOW PRE-BED DENTAL CARE FOR NSC VETERANS PRIOR TO SURGERY WHEN
          THEY MUST HAVE THEIR DENTAL CARE COMPLETED PRIOR TO INPATIENT.

 VACO ACTION:  GRANTED PENDING CHANGE IN LEGISLATION.
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OTHER LEGISLATIVE CHANGES NEEDED

ABILITY TO CARRY OVER MONEY AT END OF FISCAL YEAR

APPROVAL OF PROGRAM BY CONGRESS FOR "OFFICIAL" PROGRAM

SENATE VETERAN AFFAIRS COMMITTEE HEARING
SEPTEMBER 9, 1988
VA MEDICAL CENTER, BOISE, ID

PRIME VENDOR CONTRACTS

A PRIME VENDOR CONTRACT IS AN ACQUISITION TECHNIQUE USED IN THE PRIVATE SECTOR WHICH HAS GENERATED CONSIDERABLE INTEREST IN THE VA. A PRIME VENDOR PROVIDES A WIDE RANGE OF COMMONLY USED DRUGS AND PHARMACEUTICALS, PROVIDING 24 HOUR TURN AROUND FROM RECEIPT OF ORDER TO DELIVERY WITH A GUARANTEED FILL RATE OF 90 - 95 PERCENT. THE PRIME VENDOR GENERALLY PROVIDES ELECTRONIC ORDER ENTRY CAPABILITIES AND USEFUL, CLIENT SPECIFIC AUTOMATED REPORTS.

BOISE, VAMC IS ONE OF 5 TEST SITES SELECTED TO PARTICIPATE IN A CONTRACT BEING DEVELOPED BY VACO TO TEST THE VIABILITY AND COST-EFFICIENCY OF PRIME VENDOR CONTRACTS IN THE VA. BOISE WAS SELECTED BECAUSE WE NEGOTIATED A LIMITED VERSION OF THE PRIME VENDOR CONCEPT IN FEBRUARY OF THIS YEAR FOR URGENTLY NEEDED DRUGS. (OUR PRIME VENDOR CONTRACT IS LIMITED DUE TO MANDATORY SOURCE CONSTRAINTS). UNDER THE LIMITED PRIME VENDOR AGREEMENT, OUR URGENTLY NEEDED DRUG COSTS HAVE DROPPED APPROXIMATELY 11% FROM PRICES PREVIOUSLY PAID AND FOR EVERY ORDER PLACED ELECTRONICALLY AN ESTIMATED $100.00 IN PURCHASE ORDER ADMINISTRATIVE PROCESSING COST AVOIDANCE IS ACHIEVED. IN THE THIRD QUARTER OF THIS FY WE AVERAGED 5.6 ORDERS EVERY WORK DAY FOR URGENTLY NEEDED DRUGS.

SENATE VETERAN AFFAIRS COMMITTEE HEARING

SEPTEMBER 9, 1988

VA MEDICAL CENTER, BOISE, ID

ADVANTAGES OF PRIME VENDOR CONCEPT:

1. ELIMINATES INVESTMENT IN INVENTORY
2. ELIMINATES HOLDING & SOME HANDLING COST
3. REDUCES STORAGE SPACE REQUIREMENTS
4. REDUCES COST ON OPEN MARKET DRUGS
5. IMPROVES SERVICE TO OUR VETERAN PATIENTS.

BIDS TO BE OPENED THIS CALENDAR YEAR BY VACO WILL DETERMINE WHETHER PRIME VENDORS CAN COMPETE WITH VA DEPOT, DEFENSE LOGISTICS AGENCY AND FEDERAL SUPPLY CONTRACT DRUG PRICING.

Medical Center

500 West Fort Street
Boise ID 83702

Veterans
Administration

September 16, 1988

In Reply Refer To: 531-00

Alan Cranston, United States Senator
Chairman, Committee on Veterans' affairs
United States Senate
Washington, DC 20510-6375

Dear Senator Cranston,

1. The following comments on the CMD's Task Force report are provided as requested. Our response has been limited to the top 18 options.

OPTION A1. Feasible, Minimally Harmful - MEDIPP initiatives should only be implemented if additional resources become available or other existing programs are eliminated.

OPTION A2. Feasible, Harmful - Only a short term dollar benefit would be realized and state of the art technology would be lost. The VA healthcare system would fall rapidly behind the rest of the healthcare system.

OPTION A3. Feasible, Harmful - The dollars saved should be withdrawn from stations involved in this program and made available to the system as a whole. I agree with the con statements included with the Bell report. This is mainly a cost displacement since other payers (e.g., MEDICARE) would have to pick up the cost.

OPTION A4. Not Feasible - This option would do nothing to reduce the VA deficit and would only cause money to be shuffled within the system.

OPTION B5. Feasible, Harmful - It seems unlikely that equity of access to care will result using the vague guidelines suggested. It would make more sense to specifically eliminate certain discretionary care if the budget will not support it, (e.g., Category C veterans). Leaving it up to local discretion to treat a certain number in each category will not work. It will be difficult if not impossible to decide who to treat and who not to treat. In addition even if criteria can be established, it will be awkward trying to explain the differentiation to other veterans, the media, Congress, and Service Organ-izations. Even targeting Category C veterans in a predominately rural state will deny care to medical indigent patients who are self employed, happen to own property but have no liquid assets.

"America is #1—Thanks to our Veterans"

OPTION B6. Feasible, Somewhat Harmful - This would be beneficial if the money is not earmarked and there are assurances that if savings earned are diverted into other areas of need these funds won't be lost to the system in future years. The reduction in Community Nursing Home placements would result in longer hospital lengths of stay.

OPTION B7. Feasible, Harmful - Recommend instead accomplishing M & R projects in-house, utilizing temporary (not P & H) employees. Most renovation projects can be accomplished in this manner at considerable savings over contract or P & H methods.

OPTION B8. Not Very Feasible, Potentially Very Harmful - This would probably cause a shift in prescribing practices to more expensive prescription drugs. There is also the problem of patients not purchasing or using these prescribed over-the-counter drugs, causing their minor condition to worsen and require more expensive treatment.

OPTION B9. Not Very Feasible, Harmful - This would only shift the cost of this treatment to the Department of Health and Human Services. It would also create problems in the retention and training of Nephrologists, negatively impact the entire Internal Medicine Staff and lessen the attractiveness of having affiliations with VAMC's.

OPTION B10. Feasible, Not Harmful, - Concur with this suggestion although it does not result in any savings system wide. It merely redistributes resources.

OPTION B11. Not Very Feasible, Potentially Harmful - The savings proposed by this option will probably accrue through normal slippage of projects regardless of any overt action taken. Any intervention would only cause further delays in services and shift the costs to future years. Another approach to the subject would be to realistically look at the resources needed to activate various facilities. For instance when a VAMC is being replaced by a facility of equal size, why are significant new resources needed to operate the facility?

OPTION B12. Not Very Feasible, Harmful - As proposed this option would result in costly administrative overhead to run the program. It would be less expensive, easier to administer and result in the greatest savings if we mandated local licensure of physicians working in VAMC's and then discontinued furnishing outpatient medications to veterans who are not mandatory workload.

OPTION C13. Feasible, Harmful - On the continuum of healthcare services we should drop off those at the lower end of the spectrum in an era of constrained resources. The cessation of these programs could result in increases use of acute care programs. Suggest this option be expanded to include home health services and hospital-based home care programs as well if it is adopted.

OPTION C14. Feasible, Not Harmful - This option would not be harmful if inter-facility transfers for both inpatients and outpatients were paid.

OPTION C15. Feasible, Somewhat Harmful - In many areas upward mobility programs provide a resource for critical, hard to fill positions. There could be potential morale problems if the program was eliminated. A review of the types of positions being filled, should be conducted to determine the cost of hiring new employees verses the cost of training.

OPTION C16. Feasible, Not Harmful - This is an excellent suggestion which would remove many of the onerous extraneous requirements from staff at all levels in the Department. I believe SERP should be included on the list. Unfortunately the actual savings from this proposal are not easily identified. An FTEE reduction could be associated with this option, but reality is that most of these functions are accomplished as adjunct duties by employees who have other full time responsibilities. Therefore, with the exception of those assigned full time program responsibility at large facilities or in the Regions or VACO, very little actual savings would probably accrue.

OPTION D17. Not Feasible, Harmful - There are no real savings involved in this proposal, merely a shifting of funds from the construction appropriation to the nonrecurring M & R account to offset reductions in the latter.

OPTION D18. Feasible, Not Harmful - Recommend the elimination of all floors and ceilings. The management efficiency pilots are demonstrating that this will work very well. Let management manage.

2. In addition to the options discussed in paragraph 1, the following suggestions which were considered by the Task Force but not included in the action portion of their report should be given further consideration.

18 - Elimination of New Satellite OPC's

24 - Moratorium on RMEC Programs Involving Travel (In fact consideration should be given to the funding levels of the entire RMEC program.)

27 - Reduce Central Office, Medical District, and Regional Office Staffs (In particular, the Medical District Staffs could be greatly reduced and folded into the Regional Offices. with the current communications capability and decentralization of the RD offices, the need for separate District Offices needs to be reassessed.)

32 - Close Vet Centers (At least continue to collocation of Vet Centers on VAMC property.)

33 - Expand Management Efficiency Pilot Flexibility to All Facilities (the original RFP suggested that the Pilot could be expanded to five additional facilities at he end of the second year and extended for all facilities beyond the current three-year limitation.)

34 - Do Not Fund Any New Grecc Initiatives (After two or three years GRECC funding should become part of the RAM. Those Portions that are education and research will pass through while the clinical portions should be at risk along with all other patient care dollars.)

71 - Early Out Proposal (In particular, a number of physicians would probably retire if they were able to include their bonus in their retirement computation at an earlier date.)

3. Two additional recommendations are forwarded for your consideration.

1 Bill Third Parties for All Veterans (The VA presently only bill third party providers for non-service connected veterans, recommend this be expanded to include all veterans.

2 Utilize MEDICARE rates to pay Contract Hospitalization and Fee Basis (The VA is now using an antiquated system for establishing rates to be paid to contract healthcare providers. Outpatient visits and doctor expenses related to inpatient stays are paid on a schedule (written in 1965) adjusted for local billing pracitices. Hospital bills are paid 100% of the invoiced amount less charges for personal items. This allows for a great deal of inconsistency in amounts paid and is resulting in two agencies, Health and Human Services, and the Veterans Administration, paying greatly different amounts for the same services. All government agencies should be paying the same amount for purchased healthcare regardless of who is authorizing payment.)

4. Thank you for the opportunity to comment on this report. If I can be of any other service please let me know.

For and in absence of

JAMES A GOFF
Medical Center Director

Medical Center

4500 South Lancaster Road
Dallas TX 75216

Veterans
Administration

In Reply Refer To: 549/00

September 7, 1988

Honorable Alan Cranston
Chairman,
United States Senate
Committee on Veterans Affairs
Washington, DC 20510-6375

Dear Mr. Cranston:

Enclosed per your request are the written responses to the questions contained in your letter of August 18, 1988. If you need additional information please contact me at FTS 749-5701.

Sincerely yours,

C. Wayne Hawkins

C. WAYNE HAWKINS
Medical Center Director

Encl.

"America is #1—Thanks to our Veterans"

1. The projected (a) costs for the remainder of FY 1988 and for FY 1989 resulting from the enactment of Public Law 100-322 for (1) the increases in total reimbursements and administrative costs for the beneficiary travel program (and the annual totals for each), (2) registered nurse Saturday premium pay, (3) State home per diem increases, and (4) outpatient care for those for whom care was mandated in the new law, and (b) funding specifically provided to your facility for these costs in FY 1988 and projected to be provided for FY 1989.

(a)

	Item	FY 88 July 1-Sept 30, 1988	FY 89 Projected
(1)	Beneficiary Travel increase:		
	Reimbursements*	$67,456	$275,000
	Administrative Costs**	4,382	17,286
(2)	RN Saturday premium pay	65,000	273,000
(3)	State Home	N/A	N/A
(4)	Outpatient Care	None	None

	FY 88 Costs	FY 89 Projected Costs
* Reimbursements	$660,522	$925,000
**Administrative Costs	44,385	58,279

(b)

		FY 88 Funding	FY 89 Projected Funding
(1)	Beneficiary Travel	$100,000 nonrecurring	-0-*
(2)	RN Saturday Premium Pay	76,632 nonrecurring	-0-
(3)	Outpatient Care	-0-	-0-

*Nothing earmarked in FY 89 Target Allowance

2. The current FY 1988 (as of June 30, 1988) and projected remainder of FY 1988 and all of FY 1989 (a) costs for the payment of (1) special salary rates, (2) unfunded expenses for special drugs and other care for AIDS patients and for AIDS research, and (3) educational and training expenses resulting from the enactment of Public Law 100-322, related to the care and treatment of AIDS patients, and (b) funding specifically provided to your facility for these costs in FY 1988 and projected to be provided for FY 1989.

(a)

	FY 88 As Of 6/30/88	FY 88 7/1-9/30	FY 89 Projected
(1) Costs for Special Salary Rates	$474,617	$228,164	$905,943
(2) Unfunded Expenses-AIDS Care	$375,000	$150,000	$892,000
(3) Unfunded Expenses-Education and Training AIDS		$ 1,500	$ 15,000

(b)

	FY 88 Funding	FY 89 Funding
(1) Special Rates	$675,729	$798,918*
(2) AIDS Care	-0-	Uncertain**
(3) AIDS Education and Training	-0-	Uncertain**

* Includes $675,729 allocated in FY 88 and additional funds of $123,189 provided in the FY 89 Target Allowance.

**Our Medical Center has been identified as one of 16 facilities to receive AIDS funding in FY 89.

3. For FY 1988 (as of June 30, 1988), for the remainder of FY 1988, and for FY 1989 the (a) costs of implementing universal precautions as recommended by the Centers for Disease Control in Atlanta, Georgia, and required by the Occupational Safety and Health Administration for the purpose of protecting VA health-care workers against infectious diseases, and (b) funding specifically provided to your facility for these costs in FY 1988 and projected to be provided for FY 1989.

3.(a)	FY 88 as of June 30 187,500	FY 88 July-Sept. $62,500	FY 89 $260,000
(b)	FY 88 $ 0	FY 89 $ 0	

4. The total amount of funds shifted in FY 1988 (as of June 30, 1988), projected to be shifted for the rest of FY 1988, and projected to be shifted in FY 1989 from all non-recurring accounts, listed separately, to cover current and anticipated operational needs (please describe them).

		FY 88 As Of 6/30/88	FY 88 7/1-9/30	FY 89 Projected*
(a)	Nonrecurring Maintenance	$150,000		
(b)	Medical Equipment		$300,000	
(c)	Contract Hospitalization			$ 43,560
(d)	Community Nursing Home			224,136
(e)	Fee Basis Medical			648,000
	Totals	$150,000	$300,000	$915,696

*Contingent upon Central Office approval and also that workload and funding demands remain consistent with FY 88 levels in each of these categories.

5. As of September 30, 1987, and June 30, 1988, the total number of beds, broken down by the number of (a) critical care beds, (b) acute medical/surgical beds, (c) acute psychiatric beds, (d) long-term psychiatric beds and (e) intermediate and nursing home care beds currently not available for patient admissions. Please break down the data according to the following reasons: (1) staffing shortages due to (A) recruitment difficulties, and (B) lack of funds, (2) lack of other operating funds to support available beds, (3) then current construction or renovation projects, (4) decreased demand for beds, and (5) other reasons (please specify).

	NO. OF BEDS	NUMBER NOT AVAILABLE FOR PATIENT ADMITTED
(a) Critical Beds		
9/30/87	29	0
6/30/88	30	0
(b) Acute Medical/Surgical		
9/30/87	481	0
6/30/88	451	0
(c) Acute Psychiatric		
9/30/87	139	0
6/30/88	139	0
(d) Long Term Psychiatric		
9/30/87	31	0
6/30/88	31	0
(e) Intermediate		
9/30/87	0	0
6/30/88	29	0
Nursing Home Care		
9/30/87	120	0
6/30/88	120	0

ALL BEDS AVAILABLE FOR PATIENT ADMISSION

6. As of January 29, 1988, and June 30, 1988, the median and average waiting times in your facility for non-emergent outpatient appointments in each of the following clinics: general medicine, general surgery, orthopedic, opthamology, cardiology, urology, mental hygiene, and substance abuse.

CLINIC	1/29/88		6/30/88	
	Med.wait	Avg.wait	Med.wait	Avg.wait
General Medicine		27 days		8 days
General Surgery		7 days		11 days
Orthopedic		69 days		33 days
Opthamology		56 days		48 days
Cardiology		14 days		33 days
Urology		40 days		39 days
Mental Hygiene		3 days		1 day
Substance Abuse		6 days		7 days

7. As of January 29, 1988, and June 30, 1988, the median and average waiting times in your facility for non-emergent inpatient admissions to general medicine, general surgery, orthopedics, urology, acute psychiatry, long-term psychiatry, PTSD in-patient units, substance abuse treatment units, and intermediate and nursing home care beds.

BED SERVICE	1/29/88		6/30/88	
	Med.wait	Avg.wait	Med.wait	Avg.wait
General Medicine		3 days		1 day
General Surgery		7 days		7 days
Orthopedics		7 days		7 days
Urology		21 days		15 days
Acute Psychiatry		3 days		1 day
Long-Term Psychiatry		3 days		1 day
PTSD In-patient Untis		3 days		1 day
Substance Abuse Treatment		52 days		50 days
Intermediate		3 days		1 day
Nursing Home Care Beds		3 days		1 day

8. As of January 29, 1988, and June 30, 1988, the median and average waiting times for admission for non-emergent cardiac surgery, orthopedic surgeries requiring prostheses, and intraocular lens implants.

	As of January 29, 1988		As of June 30 1988	
	Median	Average	Median	Average
Cardiovascular	4 weeks	6 weeks	3 weeks	4 weeks
Orthopedic with Prostheses	8 weeks	6 weeks	12 weeks	12 weeks
Intraocular lens implants	2 weeks	2 weeks	2 weeks	2 weeks

9. For FY 1987 and FY 1988 (as of June 30, 1988), if your facility has its own cardiac surgery capability, the number of patients being referred to both VA and non-VA sources for such surgery and the number of such referrals and their average cost.

	FY 87	FY 88 (as of6/30/88
Number of patients referred to other facilities	0	0
Cost	NA	NA

10. For FY 1987 and FY 1988 (as of June 30, 1988), the mean and median vacancy rates for each of the following personnel categories: Psychiatrists, Radiologists, Anesthesiologists, Registered Nurses, Licensed Practical Nurses, Pharmacists, Occupational Therapists, Physical Therapists, and Respiratory Therapists.

	FY 87		FY 88	
	Mean	**Median**	**Mean**	**Median**
Psychiatrists	14%	17%	4%	6%
Radiologists	17%	18%	24%	24%
Anesthesiologists	0%	0%	0%	0%
Registered Nurses	1%	1%	2%	2%
Licensed Practical Nurses	2%	1%	2%	2%
Pharmacists	16%	16%	8%	11%
Occupational Therapists	13%	13%	0%	0%
Physical Therapists	65%	50%	50%	50%
Respiratory Therapists	2%	0%	0%	0%

Question No. 11: An estimate of the dollar reductions in inventories for drugs, medical supplies, and prosthetics during FY 1988 (as of June 30, 1988), and the number of times your facility has been depleted of critical items or medications or has experienced critical shortages of these items or medications during FY 1988.

Response to Question No. 11:

11a. An estimate of the dollar reduction in inventories for drugs, medical supplies, and prosthetics during FY 1988:

Drugs - $700,000
Prosthetics - $320,000
Medical Supplies - $180,000

11b. The number of times the facility has been depleted of critical items or medications:

Drugs: 13,454 different prescriptions were not filled on a timey basis due to lack of funds
Prosthetics: None
Medical Supplies: One time ($25,000 short fall)

11c. Experienced critical shortages of these items or medications during FY 1988:

Drugs: Since Pharmacy Service records were initiated on March 29, 1988, delays in filling 13,454 prescriptions encompassing 2,075 patients were experienced due to inadequate funding to maintain sufficient inventory levels for drugs. Attachment 1 reflects the day-to-day tracking system used by Pharmacy to identify and prioritize purchasing of out of stock medications in order to purchase medications in a timely manner consistent with less than adequate funding.

12. The current level of funds available to support contract community nursing home care payments for the balance of FY 1988 and the projected amount that will be available in FY 1989.

	FY 88 7/1-9/30	FY 89
Funds Available	$536,360	$2,571,286

13. For FY 1988 (as of June 30, 1988), the rate of surgical postponements and of cancellations due to staff shortages and an estimate of the average delay involved for postponements and what proportion of the postponements involved more than one postponement for a particular veteran.

15% of cancellations resultant of lack of Nursing Staff for second shift staffing.

.5% of cancellations constitute more than one cancellation for a particular veteran.

Medical Center

4500 South Lancaster Road
Dallas TX 75216

Veterans
Administration

In Reply Refer To: 549/001

September 15, 1988

Honorable Alan Cranston
Chairman,
United States Senate
Committee on Veterans Affairs
Washington, DC 20510-6375

Dear Mr. Cranston:

We have enclosed our responses to the questions that were distributed to the panelists in attendance at the hearing conducted by the Senate Veterans Affairs Committee on September 9, 1988. If we can be of any further assistance to you or your staff on this matter, please do not hesitate to contact us.

Sincerely yours,

FOR AND IN THE ABSENCE OF:

George H. [illegible]

C. WAYNE HAWKINS
Medical Center Director

Encl.

"America is #1--Thanks to our Veterans"

OPTIONS A-1

MEDIPP/CONTINGENCY FUNDING

This option proposes redirecting MEDIPP and Contingency funds drawn from the FY 89 Target Allowance toward the reduction of the FY 89 Budget Shortfall. This proposal, although it is aimed at solving a critical problem, will create more problems that will have a long run negative impact upon DM&S.

The MEDIPP process has gone through a period of very low field credibility during its initial years. A great deal of activity and staff time was put into the development of Strategic Plans. Insignificant action resulted from the many staff hours expended and the endless hours of coordination consumed in the development of these plans.

All this changed two years ago when earmarked funds were introduced as an "incentive" to participate in the MEDIPP process. MEDIPP actions now have real credibility. Locally, prior to the introduction of funding into the MEDIPP process, there was very little interest other than top management in the MEDIPP process.

Previously, MEDIPP was viewed as a defensive procedure/process in which every facility needed to "cover" itself by ensuring that a MEDIPP action was included for various activities and proposals. With the introduction of funding both the quantity and nature of MEDIPP actions submitted changed. Whereas, previously most MEDIPP actions focused on large major construction projects, now actions take a new character. MEDIPP actions are now more programmatic in nature. The financial incentive infused into the MEDIPP process got the attention of physicians and clinicians within the Medical Center and drew them into the MEDIPP process.

Should MEDIPP funds be withdrawn, a precedent would be set. The credibility that has been achieved with MEDIPP over the last 6 years will be lost. MEDIPP will once again be viewed by the field as a paper work exercise, which yields very little fruit. The creativity, participation and clinical interest in the MEDIPP program will be fatally damaged.

As an alternative to this option, we propose that the agency be proactive and go forward to Congress now and ask for special funding to ensure that the incentives provided by this $37 million be continued and that earmarked funds from Congress over and above the regular VA budget be provided to fulfill this purpose.

OPTION NO. A-2

DEFERRAL OF HIGH-TECHNOLOGY AND JOINT-VENTURE EQUIPMENT

If the Veterans Administration is to provide state-of-the-art treatment modalities, such as lithotripsy and diagnostic modalities, such as MRI's, then elimination of the Joint-Venture Equipment Program is not realistic. If we're going to provide these treatment and diagnostic modalities and we do not have the equipment with which to provide them, then they will have to be provided through contracts. The cost to the Veterans Administration for providing treatment and diagnoses through contracts is significantly higher than the cost of acquiring new equipment and staffing that equipment. The Joint-Venture program is a very cost effective method for the VA to acquire significant capabilities at minimum cost, because the cost of the equipment and the cost of operation of that equipment is shared jointly with another organization. The Joint-Venture equipment is utilized by those facilities that do not have sufficient needs to justify acquisition of the equipment for their sole use, but in conjunction with a nearby institution, has enough workload to be able to provide the diagnostic or therapeutic modalities at that VA facility which might not otherwise be available.

Deferral of the purchase of new and replacement high tech equipment will likewise lead to higher costs when the equipment is finally acquired due primarily to inflation. It would also delay the provision of care associated with the equipment. Inasmuch as we already have a backlog of unmet additional and replacement equipment needs, any further delays will increase the potential for the limiting or compromising of state-of-the-art therapeutic and diagnostic care.

OPTION NO. A-3

TRANSPLANTS

The DVAMC refers patients for cardiac, renal, and liver transplantation. Cardiac transplantation has been performed in approved VAMCs, generally at Richmond, Virginia. This program's funding has been cut significantly in the FY 89 budget. Additional limitations placed upon this program will further impact our ability to provide transplantation services. This proposal will exclude individual patients who presumably have severe symptom limiting cardiomyopathies and a poor prognosis. These patients will then continue to be managed by conventional means. Liver transplantation has been provided to a limited number of patients on an individual fee-for-services basis in non-VA facilities. We are unaware of any VAMC performing this procedure. These patients also have severe symptoms and a potentially terminal illness. Elimination of transplantation opportunities for these patients would mean our treatment modalities would be primarily palliative in nature. Renal transplants have not been performed at VA expense. All eligible patients have been referred to Medicare funded centers. We do not anticipate any change in this procedure. We have utilized VA facilities when feasible and safe and have used non-VA facilities only in those instances when it was not prudent to transport a veteran patient to a VA Medical Center.

OPTION A-4

RECAPTURE INCREASED COST FROM TARGET ALLOWANCE

For the CMD to withdraw all (.01) funds on one hand and to redistribute them to other accounts; i.e., salaries, would be very detrimental. Even though shortfalls exist in both all other funds (.01) and salary accounts for FY 89, to "flip flop" these funds would accomplish nothing. Any reduction of .01 all other funds would be very counterproductive. (See also Option D-18 for discussion of salaries).

At our facility, a withdrawal of the "increased cost and usage" ($658,761) will serve only to add to an already large deficit. Basically, our funds have been earmarked to apply toward a FY 89 Pharmacy deficit of $1.9 million.

OPTION NO. B-5

REDUCTION IN DISCRETIONARY WORKLOAD

We would be opposed to this concept. Current eligibility criteria are already extremely complex and confusing to most veterans. This proposal would tend to create further confusion among our veteran constituents as well as among our own clinicians who would be asked to provide more than one class of care to deserving patients. In many instances it would be detrimental to a patient's condition to treat him in one therapeutic area but not in another. Our contention is that if it is the mandate of Congress to treat a specific veteran population, then sufficient funding should be requested by the agency and allocated by the Congress.

OPTION NO. B-6

DECENTRALIZE NON-VA WORKLOAD ACCOUNTS

This option is felt to be one of the most feasible to implement with the exception of the contract hospital account. Under the contract hospital program, the law permits certain veterans to file claim for payment of emergency care within 72 hours of the admission under authorized procedures and within 2 years under unauthorized claim procedures. The number of patients, type of services, and level of care granted under fee medical, fee dental, and community nursing home programs are controllable since authorizations are given in advance of services. Patient load, type and extent of services under the contract hospital program are not controllable and unpredictable. Decentralization of this non-VA account, therefore, is not felt feasible. We believe decentralizing remaining accounts should be at the discretion of facility Directors since medical resources and veteran population varies greatly from one VA facility to another VA facility.

OPTION NO. B-7

NONRECURRING MAINTENANCE AND REPAIR

We would be opposed to this concept inasmuch as it would reduce the overall level of resources devoted to improvement of facilities and would further erode a facility's plant and equipment. The NRM program is a vital necessity to ensure the physical plant is maintained at the highest level. Reducing the funding level could create an unsatisfactory maintenance and repair environment. This is especially critical to this facility as it was constructed during the 1940/1950 era. To delay necessary M&R projects will only increase the process of deterioration and lead to increased costs in the long run due to further deterioration and inflationary costs.

OPTION NO. B.8

RESTRICT OVER-THE-COUNTER DRUGS FOR ALL PATIENTS

We support this proposal. However, before proceeding with the development of such a policy the following should be considered when defining what is meant by the term "over-the-counter"

a. Deletion of "comfort and convenience" items (medications which do not cure a disease state), e.g., bisacodyl suppository, glycerin suppository, cough syrups, antihistamines, etc.

b. Non deletion of therapeutic agents e.g., insulins, analgesics, etc., which would result in a more expensive legend item being used.

The institution of a policy to restrict over-the-counter medications must be implemented system-wide. Consideration should also be given to the stocking of various OTC items in the Canteen Service retail store.

OPTION NO. B-9

ELIMINATE CHRONIC OUTPATIENT HOME AND FEE FOR SERVICE DIALYSIS

This proposal has the potential to reduce the number of onsite dialysis patients to only a handful. The marked decrease in dialysis patients at this center would have a significant impact on our renal program. This would impair our Medical School affiliation, Research programs, Medical and Surgical housestaff training and our Renal fellowship program. The limited workload would not enable us to maintain quality and efficiency or retain qualified staff. Our current costs per patient for hemodialysis onsite are below the Medicare reimbursement rate making any savings for the Federal Government as a whole illusory.

OPTION NO. B-10

APPEAL CONGRESSIONAL GUIDANCE TO MAINTAIN EMPLOYMENT AT AIDS-IMPACTED VAMC'S

We would be opposed to this recommendation. Texas is currently ranked fifth in the number of reported AIDS cases. We are one of three Texas VAMC's that would be affected by this initiative. Without the additional monies provided by Congress, we will have to take money away from other treatment areas to support the needs of our AIDS patients. We do agree, however, that reimbursement to the AIDS-impacted VAMC's should not be provided by "taxing" other VAMC's, but rather should be through an additional appropriation from Congress.

OPTION NUMBER B-11

DELAY ACTIVATIONS OF NEWLY CONSTRUCTED FACILITIES

This option proposes foregoing the funding of activation resources for projects activating in FY 89. Although this option appears to be "quick fix" to our agency funding problems it simply sets up a ripple effect where in future years, activation fundings will also be likewise, deferred. The effort to catch up for this one year funding gap will simply defer funding for other projects unless Congress makes up the deferral with a larger than usual appropriation in later years.

Withholding activation funds for sorely needed major construction sets a precedent and erodes the agency's basis for providing new facilities. This sequence of events also tends to paint a picture of a VA unable to fulfill its promises to the veterans it is chartered to serve.

Many activation expenses associated with projects activated in '89 cannot be deferred. For example, activation funds for VA furnished contractor-installed equipment would have to be forwarded to the station, or else the VA would be held liable for compensating the contractor for deletion or delay of the project.

OPTION B-12

PAYMENT FOR PRESCRIPTIONS

We oppose the proposal to charge veteran beneficiaries for prescriptions. We believe that the cost of collection and management of the proposal would be substantial and the benefit achieved small due to the size of the discretionary veteran population. This proposal does not address those veterans unable to pay for prescriptions. Their failure to comply with a medication regimentation will result in an inpatient episode of far greater cost to the system. The negative implications for the system's public relations would be substantial.

OPTION NO. C-13

DISCONTINUE HCMI AND HOMELESS DOM PROGRAM

We would be opposed to implementation of this recommendation. The Veterans Administration has an obligation to provide care for all veterans, including homeless individuals. If it is the will of Congress to do so, then the care for these veterans should be supported by new dollar appropriations, rather than from within our already deficient existing funding.

OPTION NO. C-14

PL 100-322 AND EXISTING BENEFICIARY TRAVEL PROGRAM

The primary mission of this Medical Center is to provide quality and timely medical care to all eligible beneficiaries. Beneficiary Travel (Section 108, PL 100-322) has been identified as least beneficial in accomplishing this goal. During the past year we saw no negative impact when we had restrictions on Beneficiary Travel. We do not, however, feel total elimination of Beneficiary Travel is feasible and would, therefore, be in support of funding for beneficiary travel restricted to interfacility transfer of patients. Eliminating it totally without this provision, including funding, would not be prudent. We would suggest system-wide implementation of this option to assure uniformity at each Medical Center.

If Beneficiary Travel were implemented as stated in PL 100-322 and was not funded adequately, then this facility would be required to supplement the program from our operating funds causing us to reduce or eliminate some treatment programs now provided to our constituents.

In view of our mission, we disagree with the proposed option as it relates to Quality Assurance (Section 201, PL 100-322). This is an area we would not decrease as proposed but instead, enhance to ensure high quality health care. It is essential that we monitor the care provided in a comprehensive and integrated fashion so as to insure appropriate maintenance, change and improvement. Past facility level Quality Assurance efforts have been accomplished without additional resource support or FTEE resulting in some inconsistency and fragmentation of efforts from one facility to another. Additional funds must be made available to guarantee consistency and comprehensiveness in the Quality Assurance Program.

We disagree with the proposed option in its relation to Nurse bonus pay (Secion 212, PL 100-322). Nurse recruitment and retention has been and continues to be a major concern for the Veterans Administration. If this portion of the option were implemented, it would further jeopardize our ability to compete with the private sector by increasing the critical nurse shortage in many of our facilities. We recommend that the nurse pay bonus be implemented on a system-wide basis and additional funding be provided to each Medical Center to support the program.

Section 105 (Health Care Outside USA for SC) and 113 (Mobile Health Care) of PL 100-322 would have little immediate impact if implemented and therefore we recommend consideration be given to delaying the implementation of these programs.

OPTION NO. C-15

DECENTRALIZE VACO ACCOUNTS (NON-WORKLOAD)

We would be opposed to this recommendation. The Upward Mobility Program has been used as a vehicle to attract individuals into hard to recruit positions and has offered career enhancement opportunities to minorities and other individuals who might otherwise have been unable to reach objectives that they are capable of achieving. We believe that this is a very worthwhile program and merits the continuing support of the Agency and Congress.

OPTION NO. C-16

A MORATORIUM ON A-76 STUDIES, EFFICIENCY REVIEWS, FDPS AND OTHER SPECIAL STUDIES

This is an excellent idea. The studies and reports mentioned have been of questionable value and have been very time-consuming over the years. At this facility the efficiency reviews have failed to identify any significant additional efficiencies which can be achieved through reorganization of the activity under study. The staffing guidelines developed the last several years by Central Office have likewise been ineffective. The A-76 studies that have been bid thus far have resulted in mixed results. At this facility, the grounds maintenance bid under A-76 appears to have been won by a private sector contractor. The specifications call for an increased level of performance which the contract ostensibly will provide. This will mean no real dollar savings to the Government but should result in improved appearance of the grounds. Elimination of the facility development plan would not impact this facility as we have not done a formal facility development plan. The essential elements of a facility development plan were included in the preliminaries for the Clinical Addition and they will serve as the facility development plan.

OPTION NO. D-17

REPRIORITIZE MINOR APPROPRIATIONS PROJECTS

This is another program that supports VA facilities in maintaining their physical plant as well as medical care state-of-the-art changes, i.e. equipment, renovations, etc. that support direct patient care activities. As mentioned in response to Option No. B-7, any delay of funding in the minor project will cause our aging physical plant to suffer additional deterioration and inevitably raise costs for the project. Delays experienced in any one year tend to have a domino effect and implementation of this recommendation would have a far-reaching impact in years to come. Tampering with this program would also adversely impact equipment acquisition associated with many construction projects. Without any other significant sources of funding for new and replacement high tech, high-cost equipment, delay of the program has major negative implications for our continued ability to sustain high quality care.

OPTION NO. D-18

MANDATED EMPLOYMENT CEILING AND PERSONAL SERVICES FLOOR

We are opposed to this concept. We have a known workload to accomplish and an excellent feel for how many people it would take to accomplish that task in an effective manner. To suggest that we should reduce our employment ceiling to a level that can be supported by the available funding begs the question of how we can support the known workload with the reduced staffing. It is our firm belief that the Agency should request and Congress should support a level of FTEE and personal services dollars adequate to meet our needs. As an example, it makes no sense to reduce FTEE in our nursing staff when we already have critical shortages in such areas as evening and weekend coverage. We need the resources to support the 194,140 FTEE employment ceiling mandated by Congress as well as additional resources sufficient to meet our unfunded needs. In addition to increased funding, we would support an initiative that would eliminate individual cost center ceilings, such as currently experienced in the 400 and 500 cost centers. The elimination of these ceilings will provide Medical Center Directors with desperately needed flexibility to meet the constantly changing staffing situation at local levels.

Richard L. Roudebush
Medical Center

1481 W. 10th Street
Indianapolis, IN 46202

Veterans
Administration

September 16, 1988

In Reply Refer To: 583/00

Honorable Alan Cranston
Chairman, United States Senate Committee
on Veterans' Affairs
Washington, D.C. 20510-6375

SUBJ: UNITED STATES SENATE COMMITTEE ON VETERANS' AFFAIRS—INDIANAPOLIS VAMC RESPONSES- UPDATE

This letter replaces the September 8, 1988 response to your letter dated August 19, 1988 requesting information for the Senate Committee on Veteran Affairs. Also included (in Section B) is the written response to the questions regarding the "Chief Medical Director's Task Force Report on Fiscal Year 1989 Budget".

A. Responses to questions.

1. Projected (a) costs for the remainder of FY 1988 and for FY 1989 resulting from the enactment of Public Law 100-322 for (1) the increases in total reimbursements and administrative costs for the beneficiary travel program (and the annual totals for each), (2) registered nurse Saturday premium pay, (3) State home per diem increases, and (4) outpatient care for those for whom care was mandated in the new law.

	FY 88		FY 89	
	Increase	Total	Increase	Total
(1) Beneficiary Travel Reim	$44,000	$112,000	$140,000	$217,000
Beneficiary Travel Adm. Costs	$9,000	$18,000	$36,000	$45,000
(2) RN Saturday Premium Pay	$54,400	$54,400	$150,000	$150,000
(3) State Home Per Diem	$303,000	$2,364,000	$150,000	$2,466,000
(4) Cost of Mandated OPT Care			$400,000	*$4,200,000

* Estimation of Mandated Outpatient Care:

Our local data base does not contain detailed income levels that can be used in projecting precise cost estimates of the effects of the new law. A magnitude estimate was made assuming that approximately 70% of the outpatient workload was mandated. Outpatient workload costs were developed by multiplying the estimated mandated visits by the direct costs per visit - $36.80 (Source: VA Cost Distribution Report; excludes personal services and indirect costs).

(b) Funding specifically provided for those costs to your facility in FY 1988 and projected for FY 1989.

	FY 88	FY 89
Beneficiary Travel	$82,000	$0
Administration	$0	$0
RN Pay	$44,000	$0
State Nursing Home Per Diem	$287,000	$389,000
Cost of Mandated OPT Care	$0	$0

2. The current FY 1988 (as of June 30, 1988) and projected remainder of FY 1988 and all of FY 1989 (a) costs for the payment of (1) special salary rates, (2) unfunded expenses for special drugs and other care for AIDS patients and for AIDS research, and (3) educational and training expenses resulting from the enactment of Public Law 100-322, related to the care and treatment of AIDS patients, and (b) funding specifically provided to your facility for these costs in FY 1988 and projected to be provided for FY 1989.

(1) Special salary rates

June 88	FY 89
0	0

(2) Unfunded expenses for special drugs and other care for AIDS patients and for AIDS research.

SPECIAL DRUGS

TOTAL	$69,000
PROJECTED USAGE FY 89	$123,488

TOTAL FEE BASIS

Proj. FYTD 88	Proj. FY 88	FY 89
$34,110	$41,100	$58,800

(3) Educational and training expenses resulting from the enactment of Public Law 100-322, related to the care and treatment of AIDS patients.

	Projected FY 88	Projected FY 89
TOTAL	$40,579	$49,588

(b) Funding specifically provided to your facility for these costs in FY 1988 and projected to be provided for FY 1989.

FYTD 88	FY 88	FY 89
$0	$0	$0

3. For FY 1988 (as of June 30, 1988), for the remainder of FY 1988, and for FY 1989 the (a) costs of implementing universal precautions as recommended by the Centers for Disease Control (CDC) in Atlanta, Georgia, and required by the Occupational Safety and Health Administration (OSHA) for the purpose of protecting VA health-care workers against infectious diseases, and (b) funding specifically provided for these costs in FY 1988 and projected FY 1989.

(a) Costs of Implementing Universal Precautions.

FYTD 88	$294,252
FY 88 Projected	$350,125
FY 89 Projected	$600,500

(b) Funding specifically provided for these costs in FY 1988 and projected to be provided for FY 1989.

FY 88	$0
FY 89	$0

4. The total amount of funds shifted in FY 1988 (as of June 30, 1988), projected to be shifted for the rest of FY 1988, and projected to be shifted in FY 1989 from all non-recurring accounts, listed separately, to cover current and anticipated operational needs (please describe them).

FY 88 expected shortfall for Indianapolis $3,900,000

	Obligation Account Number	Indianapolis	Other District VAMCs	Total
REPLACEMENT EQUIPMENT	.19	$240,000	$97,000	$337,000
ADDITIONAL EQUIPMENT	.20	186,000	121,000	307,000
NRM	.23	739,000	1,879,000	2,618,000
CONTRACT HOSPITAL	.21	172,000	—	172,000
COMMUNITY NH	.24	333,000	—	333,000
ALL OTHER	.01	—	83,000	83,000
PERSONAL SERVICE		—	50,000	50,000
TOTAL		**$1,670,000**	**$2,230,000**	**$3,900,000**

FY 89 - The shortfall for FY 89 is anticipated to exceed the FY 88 level. Reprogramming levels from nonrecurring accounts have not been finalized.

5. As of September 30, 1987 and June 30, 1988, the total number of beds, broken down by the number of (a) critical care beds, (b) acute medical/surgical beds, (c) acute psychiatric beds, (d) long-term psychiatric, and (e) intermediate and nursing home care beds currently not available for patient admissions. Please break down the data according to the following reasons: (1) staffing shortages due to (A) recruitment difficulties, and (B) lack of funds, (2) lack of other operating funds to support available beds, (3) then current construction or renovation projects, (4) decreased demand for beds, and (5) other reasons (please specify).

		Sept. 30, 1987	June 30, 1988	
		Approved Operating Beds	Approved Operating Beds	Staffed Operating Beds
(a)	Critical care beds	37	37	37
(b)	Acute medical/surgical beds	273	273	268
(c)	Acute psychiatric beds	96	96	96
(d)	Long-term psychiatric beds	0	0	0
(e)	Intermediate beds	22	22	5
	TOTAL	428	428	406
(f)	Nursing home care beds	60	60	60

BED CONSOLIDATIONS

Specialty	Date	Number of beds	Reason
*Intermed. Care	4-1-88	17	Fire and Safety Project
*Neurology	4-1-88	5	Fire and Safety Project

* Taken out of service early to help reduce budgetary shortfall.

6. As of January 29, 1988, and June 30, 1988, the median and average waiting times in your facility for nonemergent outpatient appointments in each of the following clinics: general medicine, general surgery, orthopedic, ophthalmology, cardiology, urology, mental hygiene, and substance abuse.

	Jan 29, 1988		June 30, 1988	
	Days	Weeks	Days	Weeks
General Medicine (Med clinics range from 45 to 157 days)	122	17	153	22
General surgery	17	2	30	4
Orthopedic	101	14	60	8
Ophthalmology	101	14	133	19
Cardiology	182	26	184	26
Urology	62	9	184	26
Mental hygiene	314	60	8	
Substance abuse	0	0	0	0
Average of all above	77	10.8	100.5	14.1

7. As of January 29, 1988, and June 30, 1988, the median and average waiting times in your facility for nonemergent inpatient admissions to general medicine, general surgery, orthopedics, urology, acute psychiatry, long-term psychiatry, PTSD inpatient units, substance abuse treatment units, and intermediate and nursing home care beds.

	Jan 29, 1988		June 30, 1988	
INPATIENT AREA	Days	Weeks	Days	Weeks
General medicine	0	0	0	0
General surgery	30	4	32	4
Orthopedics	152	22	153	22
Urology	30	4	32	4
Acute psychiatry	0	0	0	0
Long-term psychiatry	0	0	0	0
PTSD in-patient units	N/A	N/A	N/A	N/A
Substance abuse treatment units	90	12	92	12
Intermediate	30	4	32	4
Nursing home care beds	14	2	32	4

8. As of January 29, 1988, and June 30, 1988, the median and average waiting times for admission for nonemergent cardiac surgery, orthopedic surgeries requiring prosthesis, and intraocular lens implants.

	Jan 29, 1988		June 30, 1988	
	Days	Weeks	Days	Weeks
Cardiac surgery	30	4	32	4
Orthopedic surgeries (with prosthesis)	140	20	140	20
Intraocular lens implants	0	0	0	0

9. For FY 1987 and FY 1988 (as of June 30, 1988), if your facility has its own cardiac surgery capability, the number of patients being referred to both VA and non-VA sources for such surgery and the number of such referrals and their average cost.

Cardiac Surgery Referrals

	FY 87	FY 88
VA Referrals		
# of patients	1	0
Avg. cost/patient	0	N/A
Non-VA Referrals		
# of patients	2	0
Avg. cost/patient	$16,835	N/A

10. For FY 1987, FY 1988 and FY 1988-to-date (June 30, 1988), the mean and median vacancy rates for each of the following personnel categories: psychiatrists, radiologists, anesthesiologists, registered nurses, licensed practical nurses, pharmacists, occupational therapists, physical therapists, and respiratory therapists.

	1987		1988	
	MEAN	MEDIAN	MEAN	MEDIAN
Psychiatrists	3.7%	2.9%	20%	20%
Radiologists	Contract services		Contract services	
Anesthesiologists	26.5%	23.8%	26.5%	20.8%
RNs	10.9%	10.5%	15.9%	15.7%
* LPNs	64.4%	61.3%	1.33%	4%
Pharmacists	14.1%	13.7%	10.9%	10.5%
Occupational Therapists	17.7%	17.7%	0	0
Physical Therapists	0	0	0	0
Respiratory Therapists	0	0	0	0

* Statistical abnormality based upon variations in ceiling.

11. An estimate of the dollar reductions in inventories for drugs, medical supplies, and prosthetics during FY 1988 (as of June 30, 1988), and the number of times your facility has been depleted of critical items or medications or has experienced critical shortages of these items or medications during FY 1988.

INVENTORY REDUCTIONS	
Drugs	$250,000
Medical supplies	$77,000
Prosthetics	$341,000

CRITICAL SHORTAGES	
Drugs	0
Medical supplies	*0
Prosthetics	*0

* Low inventories have resulted in frequent borrowing for surgery operating room supplies and prosthetic devices from our university affiliate.

12. The current level of funds available to support contract community nursing home care payments for the balance of FY 1988 and the projected amount that will be available in FY 1989.

BALANCE OF FY 88	$490,000
PROJECTED FOR FY 89	$2,563,614

13. For FY 1988 (as of June 30, 1988), the rate of surgical postponements and of cancellations due to staff shortages and an estimate of the average delay involved for postponements and what proportion of the postponements involved more than one postponement for a particular veteran.

Number of Procedures	3,918
Rate of Surgical Postponements	2%
Cancellations due to Staff Shortages	80
Average Delay	2 days
Percent of Repeat Postponements	25%

B. At the recent hearing of the Senate Committee on Veterans Affairs, the Chairman requested a written response to the following questions regarding the "Chief Medical Director's Task Force Report on Fiscal Year 1989 Budget":

1. Do you believe that these options should be implemented nationally or that Regional Directors or even facility Directors should be given discretion as to which among an approved list of options should be implemented?

The determination of the level of discretionary authority (national regional or local) should follow the principal of placing the decision making authority at a level as close as possible to the delivery of service. Each of the eighteen options should be evaluated for feasibility nationally. Depending upon the specific option, implementation may occur at the national, regional or local level as determined to be most appropriate. Options that significantly affect a veteran's entitlement or access to medical care should be addressed nationally. Option No. B-5, "Reduction in Discretionary Workload"; No. B-12, "Payment for Prescriptions"; No. C-14, "Beneficiary Travel", would be examples of issues requiring national direction. The direction should come as a national framework that generally guides any necessary reductions in entitlement or access to care. The national guidance should permit some regional and local flexibility to best accommodate the necessary changes.

Other options such as B-6, "Decentralize Non-VA Workload Accounts"; No. B-7, "Nonrecurring M&R", could be implemented by local management under a broad delegation by VA Central Office.

2. Please provide in writing any suggestions you have to offset the FY 1989 shortfall.

The list of the suggested 86 options (Attachment A) considered by the CMD's Task Force on the FY 1989 operational shortfalls was generated through a broad based participatory process. My suggestions to offset the FY 1989 shortfalls are already represented in this comprehensive list. I have no additional suggestions at this time.

Terrence Johnson

TERRENCE L. JOHNSON
Medical Center Director

The Veterans Administration's Management Efficiency Pilot Program (MEPP) is a three year program to test whether relieving VA facilities of many of the centralized restrictions results in more efficient operations, i.e., "freeing managers to manage." Improvements are projected in three broad areas: effectiveness and efficiency, timeliness of service to veterans and broadening the range of services while maintaining high quality standards. The Indianapolis VA Medical Center is one of five MEPP sites in the Department of Medicine and Surgery. In July 1987, 124 Agency-level waivers were initially approved by the Administrator, prior to program initiation in October 1987. Since that time, over 200 waivers have been submitted by the five DM&S MEPP sites for consideration by VA Central Office. More than 80 of the waivers have been granted as written or conditionally granted as of September 21, 1988.

At Indianapolis, MEPP has become a revitalizing project to challenge the way we do business. With the theme of "Bureaucracy Busters," employees at all levels have contributed suggestions on ways to improve Medical Center operations. Waivers are submitted when required, but in many cases waivers are not required and implementation takes place within present authority. Whenever possible, suggestions are implemented quickly so positive feedback is provided to the employees. MEPP is creating a can do attitude throughout the Medical Center and employee morale is increasing as a result.

Waivers and the resulting expansion of management flexibility have increased our ability to redirect funds from one area to another, depending on need. In fiscal year 1988, significant dollars were redirected from non-VA workload accounts to direct patient care accounts to assist in covering shortages. The result was a more effective use of those funds.

Existing reporting requirements are reviewed to determine if the collection of information is essential to the operation of the Medical Center and/or vital to meeting higher level VA requirements. As a result, a number of low return reporting requirements have been eliminated and considerable employee time has been redirected to more critical tasks. .

Many actions which required VA Central Office review and approval prior to MEPP can now be accomplished locally, providing a process which is more responsive to the needs of the Medical Center and its patients. This has avoided delays of days, weeks, and, in some instances, months in such areas as equipment acquisition, personnel selection decisions, excess equipment redistribution, equipment testing, leases of real property and sharing agreement contracts.

The use of excused time off and flexible scheduling has provided incentives for employees to increase efficiency and decrease overtime and leave usage. Increased morale is another benefit.

Patient satisfaction with meals has increased since a change in menu cycles was implemented. The change also has reduced the number of food items stocked and the time required to prepare meals. Service to the patient has improved at the same time the operation has become more efficient.

Through the first year of MEPP, the Medical Center has initiated a number of improvements, and the program has potential to allow more. Since fiscal year 1988 was such a financially tight year, the Medical Center was unable to generate seed money to implement suggestions or programs that required a large initial investment but demonstrated an effective payback. With fiscal year 1989 developing as another financially tight year, it is doubtful that any suggestions requiring outlay of substantial funds can be implemented unless the payback can be achieved within the fiscal year.

Additional flexibility is desired by this MEPP site in areas of procurement, personnel and fiscal procedures. For example, with the flexibility of carrying funds over to the next fiscal year, a medical center might be able to accumulate savings to be able to invest in labor-saving equipment or hire staff to provide a service at lower cost than is now performed under contract.

A legislative initiative has been proposed by the Veterans Administration to grant further flexibility to the MEPP sites. Some of the waivers which have been granted subject to legislative change cannot be implemented without the necessary changes. This Medical Center looks forward to further legislative relief as another step in "freeing managers to manage."

The Indianapolis VA Medical Center is committed to making MEPP a success by improving effectiveness and efficiency, timeliness of service and by increasing the range of services. From the experience of the first year of the program, MEPP is already considered successful and there is potential to do much more.

Richard L. Roudebush
Medical Center

1481 W. 10th Street
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Veterans Administration

September 15, 1988

In Reply Refer To: 583/00

Honorable Alan Cranston
Chairman, United States Senate Committee
on Veterans' Affairs
Washington, DC 20510-6375

SUBJ: UNITED STATES SENATE COMMITTEE ON VETERANS' AFFAIRS-INDIANAPOLIS VAMC RESPONSES

This is in response to your letter of September 12, 1988 requesting follow-up information on Veterans' Administration health-care oversight hearing.

A. Please describe those options from the report that you believe are most feasible to implement and those that would be most disruptive and harmful. You may restrict yourself to the top 18 options, if you wish.

All of the options will be somewhat disruptive. The options are under consideration because of an anticipated significant budgetary shortfall. In the absence of a serious funding situation, I would recommend that none of the 18 options be implemented. In specific response to the question, I have arrayed in rank order from most feasible to implement to most disruptive and harmful:

1. D16. A Moratorium on A-76 Studies, Efficiency Reviews, FDPs
2. B6. Decentralize Non-VA Workload Accounts
3. B10. Appeal Congressional Guidance to Maintain Employment at AIDS-Impacted VAMCs
4. C13. Discontinue HCMI and Homeless Dom Programs
5. C14. PL 100-322 & Existing Beneficiary Travel Program
6. B8. Restrict Over-the-Counter Drugs for All Patients
7. B12. Payment for Prescriptions
8. A2. Deferral of High-Tech and Joint Venture Equipment
9. A3. Transplant
10. A1. MEDIPP/Contingency Funding
11. B7. Nonrecurring Maintenance and Repair
12. D17. Reprioritize Minor Appropriations Projects
13. B11. Delay Activations of Newly Constructed Facilities
14. B9. Eliminate Chronic Outpatient Home and Fee Service Dialysis
15. D18. Mandated Employment Ceiling & Personnel Services Floor
16. C15. Decentralized VACO Accounts (NON-WORKLOAD)
17. B5. Reduction in Discretionary Workload
18. A4. Recapture Increased Cost From Target Allowance.

B. Please provide in writing any suggestions you have to offset the FY 1989 shortfall.

The list of the suggested 86 options (Attachment A) considered by the CMD's Task Force on the FY 1989 operational shortfalls was generated through a broad based participatory process. My suggestions to offset the FY 1989 shortfalls are already represented in this comprehensive list. I have no additional suggestions at this time.

Terrence Johnson

TERRENCE L. JOHNSON
Medical Center Director

RESPONSES TO CHAIRMAN CRANSTON'S WRITTEN QUESTIONS

FROM DR. A. WENDELL MUSSER

TO: United States Senate
Committee on Veterans Affairs

SUBJ: Committee oversight hearings on the adequacy of VA resources.

Following are the specific responses to your questions regarding the Atlanta VA's capability to meet veterans health care needs for the remainder of the FY-88 and for FY-89.

1. (A) Estimated Fourth Quarter FY-88 and FY-89 costs resulting from enactment of Public Law 100-322.

	4th Qtr FY-88	FY-89
1. Increase in total reimbursements and administrative cost for the beneficiary travel program as follows:		
a) Administrative Cost increases	-0-	-0-
b) Reimbursement increases	$120,000	$500,000
2. Registered Nurse Saturday Premium Pay	$ 50,000	$200,000
3. State Home per diem increases	--------	---------
4. Outpatient care for those whom care was mandated in the new Law	$ 60,000	$240,000

(B) Funds available for these costs for the same time periods mentioned above.

1. Increase in total reimbursements and administrative costs for the beneficiary travel program as follows:		
a) Administrative Cost increases	-0-	-0-
b) Reimbursement increases	-0-	-0-
2. Registered Nurse Saturday Premium Pay	-0-	-0-
3. State Home per diem increases	-------	-------
4. Outpatient care for those whom care was mandated in the new Law	-0-	-0-

2. Projected information concerning special rates and AIDS.

	Actual 6/30/88	FY-88 Projected 9/30/88	FY-89 Total
A. Special Salaries	$398,000	$530,662	$530,662
B. Funding available for special salaries	$271,500	$361,662	$361,662
C. Unfunded expenses for special drugs and other care for AIDS patients and for AIDS Research (include universal precautions	$200,000	$300,000	$500,000
B. Estimated cost of education and training resulting from the enactment of PL 100-322, related to the care and treatment of AIDS patients	$ 4,000	$ 6,000	$ 10,000

3. Estimated cost to implement universal precautions as recommended by the Center of Disease Control in Atlanta and as required by the Occupational Safety and Health Administration for the purpose of protecting VA health care workers against infectious diseases.

	Qtrs 1,2 & 3 FY-88	Quarter 4 FY-88	FY-89
A. Universal Precautions for AIDS*	$ 99,000	$ 52,000	$638,000
B. Universal Precautions for other infectious diseases*			

*Amounts shown above include universal precaution costs for AIDS and other infectious diseases. It is not possible to develop an accurate breakdown between the two categories.

4. A total of $581,334 has been shifted during FY-88 from non-recurring accounts to cover operational needs. These funds were shifted from the following non-recurring accounts.

Replacement Equipmewnt	$71,321	
Additional Equipment	133,313	
		$204,634
Maintenance & Repair Projects		
Delta Upgrade	$90,000	
Parking Lots	154,120	
Weather Proofing	33,000	
Ambulatory Care Walls	77,410	
T.V. Antenna	22,170	
		$376,700
TOTAL		$581,334

These funds were utilized during FY-88 to help offset operational needs in the following accounts:

- RN Contract Coverage
- AIDS patients drugs and medical supplies
- Increased cost and usage "all other" accounts
- Beneficiary travel
- Within-grade salary cost
- Saturday Premium Pay
- Special pay rates
- Third Party billing costs

The anticipated shortfall in FY-89 funding for this medical center is five million dollars. Because of the age and utilization of the medical center's buildings and equipment, it is essential that all funds made available in the non-recurring equipment and project accounts for FY-89 be used for those purposes.

5. Total number of beds by category and the reason they were not available for patient admission as of September 30, 1987 and June 30, 1988.

Reason	Critical Care	Acute Med/Sur	Acute Psych	L.T. Psych	Intermed or VA NHCU
A. Data for September 30, 1987.					
1. Staff shortages due to:					
a. Recruitment Difficulties		68			
b. Lack of funds					
2. Lack of operating funds to support available beds		57			
3. Current construction or renovation					
4. Decreased demand for beds					
5. Other reasons (please specific					
6. TOTALS		125			
B. Data for June 30, 1988					
1. Staff shortages due to:					
a) Recruitment Difficulties		38			
b) Lack of funds					
2. Lack of operating funds to support available beds		57			
3. Current construction or renovation					
4. Decreased demand for beds					
5. Other reasons (please specify					
6. TOTALS		95			

+6. Estimated average waiting times for non-emergent outpatient appointments.

AREA	as of January 29, 1988	as of June 30, 1988
A. General Medicine	--	1 week
B. General Surgery	4 weeks	2 weeks
C. Orthopedic	5 weeks	6 weeks
D. Ophthalmology	5 weeks	3.5 weeks
E. Cardiology	4 weeks	5 weeks
F. Urology	11 weeks	9 weeks
G. Mental Hygeine	5-6 weeks	5-6 weeks
H. Substance Abuse	No waiting time	No waiting time

+7. Estimated average waiting times for non-emergent inpatient admissions.

AREA	as of January 29, 1988	as of June 30, 1988
A. General Medicine	No waiting time	No waiting time
B. General Surgery	2 weeks	2 weeks
C. Orthopedics	3 months	3 months
D. Urology	6 weeks	10 weeks
E. Acute Psychiatry	1 week	1-2 weeks
F. Long-Term Psychiatry	2 weeks	3-4 weeks
G. PTSD In-patient Units (no unit--transfer to Augusta)	3-4 weeks	3-4 weeks
H. Substance abuse Treatment Units	1 day	1 day
I. Intermediate	10 days	10 days
J. NHCU Beds	No waiting time	No waiting time

+8. Estimated average waiting time for non-emergent cardiac, surgery, orthopedic surgeries requiring prostheses, and intraocular lens implants.

	as of January 29,1988	as of June 30, 1988
A. Cardiac Surgeries	5 weeks	1 week
B Orthopedic Surgeries with prostheses	3 months	3 months
C. Intraocular Lens implants	2 weeks	2 weeks

+9. The number and cost of patients being referred to both VA and non-VA sources for Cardiac Surgery.

A. LOCATION OF REFERRAL	FY1987	COST
VAMC Ashville	73	No cost to VA, Atl.
VAMC Augusta	8	No cost to VA, Atl.
Crawford W. Long	88	Average Cost=$11,030 (51 CABG & 37 PTCA)
	FY1988	
B. VAMC Ashville	10	No cost to VA, Atl.
VAMC Augusta	7	No cost to VA, Atl.
Crawford W. Long	58	Average Cost $3,724 (2 CABG & 56 PTCA)

+10. Estimated figures for FY1987 and FY1988 for the mean and median vacancy rates for the following personnel categories:

	FY1987	FY1988
A. PSYCHIATRISTS	35% mean vacancy	35% mean vacancy
	4.8 FTE median vacancy	4.8 FTE median vacancy
B. RADIOLOGISTS	0% mean vacancy	0% mean vacancy
	0 FTE median vacancy	0 FTE median vacancy
C. ANESTHESIOLOGISTS	0.15% mean vacancy	0.15% mean vacancy
	0.6 FTE median vacancy	0.6 FTE median vacancy
D. REGISTERED NURSES	12.7% mean vacancy	9.98% mean vacancy
	44 FTE median vacancy	28 FTE median vacancy
E. LICENSED PRACTICAL NURSE	10.5% mean vacancy	5.6% mean vacancy
	11.8 FTE median vacancy	6.3 FTE median vacancy
F. PHARMACISTS	31% mean vacancy	11% mean vacancy
	7.5 FTE median vacancy	3.25 FTE median vacancy
G. OCCUPATIONAL THERAPISTS	29% mean vacancy	29% mean vacancy
	1 FTE median vacancy	1 FTE median vacancy
H. PHYSICAL THERAPISTS	0% mean vacancy	0% mean vacancy
	0 FTE median vacancy	0 FTE median vacancy
I. RESPIRATORY THERAPISTS	19% mean vacancy	13% mean vacancy
	3 FTE median vacancy	3 FTE median vacancy

*11. A. During FY1988, approximately $1.5 million have been reduced in inventories for drugs, medical supplies, and prosthetics.

B. Data on actual occurrences in not available.

12. The current level of funds available to support contract community nursing home payments is:

FY1988 - $3,976,068

FY1989 - $4,354,304
The funds available in support of this program is adequate for both fiscal years.

*13. Estimate of surgical postponements and cancellations due to staff shortages, etc. as of June 30, 1988.

A.	Inpatient cases scheduled during period	2,744
B.	Inpatient cases canceled during period due to lack of surgical or ICU staff/ or not scheduled**	9/325**
C.	Outpatient cases scheduled during period	420
D.	Outpatient cases canceled due to lack of staff to perform the surgery	12

E. Estimate of time delay before rescheduling:

Inpatient	3 days
Outpatient	14 days

F. How many patients suffered multiple cancellations due to lack of staff in either surgery or ICU. Unknown- Data not kept.

** 325 patients were not scheduled due to our inability to staff one of our operating rooms during this time.

---

* Responses identical to those provide for the SVAC Questionnaire.

+ Response cross references material in SVAC Questionnaire but is not identical.

Medical Center
(Atlanta)

1670 Clairmont Road
Decatur GA 30033

Veterans
Administration

September 16, 1988

In Reply Refer To:

Honorable Alan Cranston, Chairman
Committee on Veterans' Affairs
United States Senate
Washington, D C 20510-6375

Dear Senator Cranston:

In response to the follow-up questions in connection with the hearings before the Committee of Veterans' Affairs of September 9, 1988, I would like to make the following comments:

Question 1--As you may or may not be aware, I was part of the membership of that Chief Medical Director's Task Force that addressed the fiscal year 1989 shortfalls. I am in agreement unanimously with the recommendations stated in that report and would personally suggest that if necessary all of those options for which the Chief Medical Director has explicit authority be immediately adopted if it is not possible for the Congress to supply in a short timeframe the supplemental funds necessary to maintain current services. Those options for which he has immediate authority without consultation consists of setting aside the MEDIPP contingency funding, deferring all high tech and joint equipment ventures, restricting transplants to service-connected patients and not allowing the development of any new programs and recapturing all increased cost and issue money already distributed in the target allowance. I would proceed post haste to gain consultation and authority for all of the rest of the 18 actions in the priorities listed in the document. Introduction of any of these options in order to maintain current services will obviously wrench the system.

Question 2--My main suggestion at this time without bona fide evidence that the Congress can respond in an appropriate timeframe, I would ask for immediate legislation to at least temporarily set aside many of the provisions of PL-100-322 and concentrate my efforts for supplemental upon those budget shortfalls in the FY/88 budget that will naturally roll over into the FY/89.

Question 3--Also you may or may not know, I have served on the Chief Medical Director's RAM Task Force for the last two years. It is an excellent resource distribution mechanism but like all man made things it is imperfect and has its shortcomings. In addition, because of lack of control of operational officials, it has stimulated workload in many areas of the country of a low priority nature. Since the system is a zero sum system, that artifical stimulation has resulted in the detraction of dollars away from heavier workloads of a higher priority. If the RAM Task Force is allowed, it will introduce a new and better integrated patient cost system that will monitor and control these types of aberations. It was the considerated opinion of the Task Force that during these times of culminated budgetary devices that the present RAM methodology constituted a unnecessary negative factor in the decision making process. Our suggestion is to continue to run the RAM as a management tool but to not apply it as a resource distribution mechanism. Hopefully, anyone with due thought and consideration will never consider going back to the old historical "good ole boy" method of distributing resources.

I enjoyed so much my time before your committee and it was a pleasure to watch your performance in your usual masterful way.

Sincerely,

A. WENDELL MUSSER, M.D.
Chief of Staff

Veterans
Administration

Memorandum

Date: August 25, 1988

From: Thomas F. Newcomb, M. D.
Chief of Staff, VAMC, Durham, N.C.

Subj: Oversight Hearing on VA Resources

To: Sandra Isaacson
Professional Staff Member
Majority Staff Aide
Committee on Veterans Affairs

1. Projected costs and reimbursement resulting from enactment of Public Law 100-322:

	Costs		Funding	
	FY 88	FY 89	FY 88	FY 89
-Total reimbursement costs for beneficiary travel program	64,319	262,905	77,673	0
-MAS total administrative cost for beneficiary travel program	35,929	37,034	0	0
-RN Saturday Premium pay	63,165	131,382	45,157	0
-State home per diem increases	0	0	0	0
-Outpatient costs for those whom care was mandated in new law	0	0	0	0

2. Costs for payment of:

	Costs		Funding	
	Current FY 88	FY 89	FY 88	FY 89
-Special Salary Rates	381,478	726,823	306,600	301,661*
-Unfunded expenses for AIDS patients and research	90,333	117,298	0	0

* Special Salary Rate/Pharmacists	46,130
Special Salary Rate/RN's	255,531

3.

	FY88 To Date	FY88 Remaining	FY89(Est.)
Needle Disposal:	$6,900.00	$1,830.00	$10,980.00
Chemical Waste Containers:	1,296.00	480.00	2,295.00
Gloves (Bldg. Mgt.):	485.00	82.00	567.00
TOTAL:	**$8,681.00**	**$2,392.00**	**$13,842.00**

GLOVES:

	FY88 To Date	FY88 Remaining	FY89(Est.)
Exam, Vinyl (med.)	22,812.50	4,562.50	30,950.00
Exam, Vinyl (sm.)	13,034.50	2,606.50	17,675.00
Surgeons (Sz 6.5)	20,413.40	4,082.68	27,680.00
Surgeons (Sz 7)	8,424.00	1,684.80	33,696.00
Surgeons (Sz 7.5)	13,853.00	2,770.60	47,496.00
Surgeons (Sz 8)	28,693.80	5,738.76	38,963.00
Surgeons (Sz 8.5)	495.00	99.00	2,700.00
TOTAL:	**$107,726.20**	**$21,544.84**	**$199,160.00**

	FY88 To Date	FY88 Remaining	FY89(Est.)
Protective Wear Dispenser Systems:	$ 3,200	0	0
Eye Shields:	220.00	0	220.00
TOTAL:	**$3,420.00**	**0**	**$220.00**
OVERALL TOTALS:	**$119,827.20**	**$23,936.84**	**$213,222.00**

HIV Antibody Testing: If information on the number of tests completed for needle sticks, etc. is needed, I can get it to you.

4. The total amount of funds shifted in FY 88 from all Non-Recurring accounts to cover current and anticipated operating needs are:

10/1/87 through 6/30/88

Purpose	Amount	From
Supplies	114,008	Replacement Equipment
Supplies	102,662	Additional Equipment
Supplies	369,000	Maintenance & Repair

5. The number of beds which were out of service on September 30, 1987 and June 30, 1988 are:

a. 9/30/87 - Acute Medical/Surgical - 97 Beds out of Service

b. 6/30/88 - Actue Medical/Surgical - 116 Beds out of Service
Critical Care - 11 Beds out of Service
TOTAL 127

On both of these dates, all beds which were out of service, were unavailable due to nursing shortages caused by recruitment and retention difficulties.

6. Next available clinic appointment in the following clinics for a non-emergent outpatient:

		1-29-88	6-30-88
A.	General Medicine	2-29-88	7-30-88
B.	General Surgery	2-15-88	7-16-88
C.	Orthopedics	5-1-88	10-1-88
D.	Opthalmology	4-1-88	9-1-88
E.	Cardiology	3-1-88	8-1-88
F.	Urology	8-12-88	2-2-89
G.	Mental Hygiene	2-10-88	7-15-88
H.	Substance Abuse	No Clinic	

note.

*Note: This facility tracks availability in 76 outpatient clinics; in 22 clinics the next available appointment is greater than 8 weeks.

7. Next available non-emergent admission:

		1-29-88	6-30-88
A.	General Medicine	2-7-88	7-6-88
B.	General Surgery	2-7-88	7-6-88
C.	Orthopedics	2-14-88	7-19-88
D.	Urology	2-7-88	7-6-88
E.	Alcohol and Drug Treatment Units	N.A.	
F.	Acute and Long Term Psychiatry	Psych.does not schedule admissions other than O&E's.	
G.	Intermediate and Nursing Home Care	N.A.	
H.	PTSD Units	N.A.	

*Note these times do not reflect the numerous occasions in which non-emergent patients are admitted for procedures or operations which are cancelled due to urgent or emergent patients.

8. Next available scheduled admission for non-emergent admission for:

	1-29-88	6-30-88
a. Cardiac surgery:	2-15-88	7-18-88
b. Orthopedic surgeries requiring prostheses:	3-29-88	8-30-88
c. Intraocular implants:	2-12-88	7-14-88

*Note: Non-emergent patients' surgery are often cancelled after admission because of emergent cases.

9. Number Hospitals that have cardiac surgery capabilities that are referring patients to both other VA and non-VA programs:

Number of patients referred (in 1987 and FY 88 to date) for emergency surgery

1987	0
1988	5

a. Number of cardiac surgeries performed: (At Durham)

1. FY87 - 158

2. FY thru 6-30-88 - 141

b. Number and source of cardiac surgeries at Durham VAMC

	PSA	Outside PSA
1. FY87	78 or 49.4%	80 or 50.6%
2. FY thru 6-30-88	80 or 56.7%	61 or 43.3%

3. Average cost per cardiac surgery: $14,220.

Valve replacement actual cost approximately $18,500.

10. FY87 and FY88-to-date, the mean and median vacancy rates, the location and rate of the five facilities with highest and the five with the lowest such rates for each of the following personnel categories:

	FY-87		FY88	
	Mean	Median	Mean	Median
Psychiatrists	1	1	2	2
Radiologists	0	0	0	0
Anesthesiologists	0	0	0	0
Registered nurses *	29	25	37	34
Licensed practical nurses **	9	7	9	9
Pharmacists	2	2	2	2
Occupational therapists	0	0	0	0
Physical therapists	0	0	0	0
Respiratory therapists	1	1	1	1

* Low of 22 RN vacancies and high of 35 in FY87

* Low of 32 RN vacancies and high of 44 in FY88

** Low of 1 LPN vacancy and high of 17 in FY87

** Low of 6 LPN vacancies and high of 12 in FY88.

Other personnel categories impacting patient care where recruitment problems exist include Radiology Tech., CRNA's and medical technicians.

11. $ reduction estimate in inventories for drugs, medical supplies and prosthetics as result of inadequate funds in FY88:

a. Drugs	$181,548
b. Medical	259,912
c. Prosthetics	37,343
	$478,803

12. The current levels of funds available to support Contract Community Nursing Home Care payments for the balance of FY 88 is $576,130. The projected amount that will be available in FY 89 is $2,476,160 which is reflected on the FY 89 Target Allowance.

13. The rate of surgical postponements and cancellations due to staff shortages for the period March 1988 - July 1988 is attached. January and February 1988 data is not available.

				1988		
	Mar	Apr	May	Jun	Jul	Subtotal
Inadequate Anes Coverage (am)	0	6	6	0	4	16
Inadequate OR Coverage (am)	0	5	7	0	0	12
Inadequate Anes/OR Coverage (pm)	8	4	34	35	50	131
No RR bed available (staff)	3	3	2	3	1	12
No SICU bed available (staff)	1	2	2	2	1	8
SUBTOTALS	12	20	51	40	40	56
TOTALS						179

Data regarding the number of postponements for a particular veteran or the average time involved for each postponements is not currently available.

Medical Center

508 Fulton Street
Durham NC 27705

Veterans
Administration

September 19, 1988

In Reply Refer To: 558/11

Honorable Alan Cranston, Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510-6375

Dear Chairman Cranston:

In response to your letter of September 12, 1988, I offer the following comments. The 18 options described by the CMD Task Force can be roughly grouped into three categories: The first category includes options which might be implemented on a short-term basis and would reduce the budget but at a cost of decreasing services to veterans. The second category would be to delay expenditures during the near term in a way which would almost guarantee additional cost later on. The third category is essentially a transfer of funds which will not save the taxpayer monies although it might temporarily relieve the VA's budget problems.

Included in feasible first category options would be the following:

A-1 MEDIPP/CONTINGENCY FUNDING

A-2 DEFERRAL OF HIGH-TECHNOLOGY AND JOINT-VENTURE EQUIPMENT

B-5 REDUCTION IN DISCRETIONARY WORKLOAD

B-6 DECENTRALIZE NON-VA WORKLOAD ACCOUNTS

B-8 RESTRICT OVER-THE-COUNTER DRUGS FOR ALL PATIENTS

C-13 DISCONTINUE HCMI AND HOMELESS DOM PROGRAMS

C-16 A MORATORIUM ON A-76 STUDIES, EFFICIENCY REVIEWS, FDPs AND OTHER SPECIAL STUDIES

D-18 MANDATED EMPLOYMENT CEILING AND PERSONAL SERVICES FLOOR

Of this group those having the least effect on provision of services to veterans are A-2 and C-16.

Those options which would put off expenses until the future include the following:

B-7 NONRECURRING MAINTENANCE AND REPAIR

B-11 DELAY ACTIVATIONS OF NEWLY CONSTRUCTED FACILITIES

D-17 REPRIORITIZE MINOR APPROPRIATIONS PROJECTS

"America is #1—Thanks to our Veterans"

The remaining options might or might not interfere with patient services depending upon how they are implemented. However, they have the general characteristic that there is no true savings to the government but rather that funds are being shifted about.

With regard to option C-14 PL 100-322 AND EXISTING BENEFICIARY TRAVEL PROGRAM, the savings from nurse bonus pay would likely be interpreted as a major setback to enhance the nurses' role in the Department of Medicine and Surgery. Given the present crisis in provision of nursing services, this would be adverse from the field's point of view.

Unfortunately, I do not have any better ideas than those presented by the Task Force. During the hearings, Senator Murkowski commented on further exploration of private sector capabilities which leads me to suggest the following. In some locations where the veteran is underserved because VA hospitals are not available, it might be possible to hire full-time VA physicians who would actually function through the use of contract beds in the private hospital. This might be a useful mechanism to employ where for example we have clinics at great distances from their parent hospitals. Patients who require brief hospitalization would then be taken care of locally rather than have to go long distances to the nearest VA Medical Center. Since the controlling physician would be a full-time VA employee concerns about over usage and profiteering could be somewhat offset.

I appreciate the opportunity to provide this additional testimony and stand available to serve if I might be of any help.

Sincerely yours,

Tom Newcomb

THOMAS F. NEWCOMB, M.D.
Chief of Staff

ALAN CRANSTON, CALIFORNIA, CHAIRMAN

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JONATHAN R. STEINBERG, CHIEF COUNSEL/STAFF DIRECTOR
ANTHONY J. PRINCIPI, MINORITY CHIEF COUNSEL/STAFF DIRECTOR

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510-6375

August 18, 1988

Mr. Robert Lindsey
Director
Veterans' Administration Regional
Office
211 Main Street
San Francisco, California 94105

Dear Bob,

As I stated in my August 9, 1988, letter to you, I am sending you a list of those matters about which the Committee has a particular interest. Regarding your region, it would be appreciated if you bring to the Committee's September 9, 1988, hearing written data in response to the following questions.

1. The projected (a) costs for the remainder of FY 1988 and for FY 1989 resulting from the enactment of Public Law 100-322 for (1) the increases in total reimbursements and administrative costs for the beneficiary travel program (and the annual totals for each), (2) registered nurse Saturday premium pay, (3) State home per diem increases, and (4) outpatient care for those for whom care was mandated in the new law, and (b) funding specifically provided to your region for these costs in FY 1988 and projected to be provided for FY 1989.

2. The current FY 1988 (as of June 30, 1988) and projected remainder of FY 1988 and all of FY 1989 (a) costs for the payment of (1) special salary rates, (2) unfunded expenses for special drugs and other care for AIDS patients and for AIDS research, and (3) educational and training expenses resulting from the enactment of Public Law 100-322, related to the care and treatment of AIDS patients, and (b) funding specifically provided to your region for these costs in FY 1988 and projected to be provided for FY 1989.

3. For FY 1988 (as of June 30, 1988), for the remainder of FY 1988, and for FY 1989 the (a) costs of implementing universal precautions as recommended by the Centers for Disease Control in Atlanta, Georgia, and required by the Occupational Safety and Health Administration for the purpose of protecting VA health-care workers against infectious diseases, and (b) funding specifically provided to your region for these costs in FY 1988 and projected to be provided for FY 1989.

4. The total amount of funds shifted in FY 1988 (as of June 30, 1988), projected to be shifted for the rest of FY 1988, and projected to be shifted in FY 1989 from all non-recurring accounts, listed separately, to cover current and anticipated operational needs (please describe them).

5. As of September 30, 1987, and June 30, 1988, the total number of beds, broken down by the number of (a) critical care beds, (b) acute medical/surgical beds, (c) acute psychiatric beds, (d) long-term psychiatric beds, and (e) intermediate and nursing home care beds currently not available for patient admissions. Please break down the data according to the following reasons: (1) staffing shortages due to (A) recruitment difficulties, and (B) lack of funds, (2) lack of other operating funds to support available beds, (3) then current construction or renovation projects, (4) decreased demand for beds, and (5) other reasons (please specify).

6. As of January 29, 1988, and June 30, 1988, the median and average waiting times for non-emergent outpatient appointments in each of the following clinics: general medicine, general surgery, orthopedic, ophthamology, cardiology, urology, mental hygiene, and substance abuse.

7. As of January 29, 1988, and June 30, 1988, the median and average waiting times for non-emergent inpatient admissions to general medicine, general surgery, orthopedics, urology, acute psychiatry, long-term psychiatry, PTSD in-patient units, substance abuse treatment units, and intermediate and nursing home care beds.

8. As of January 29, 1988, and June 30, 1988, the median and average waiting times for admission for non-emergent cardiac surgery, orthopedic surgeries requiring prostheses, and intraocular lens implants.

9. For FY 1987 and FY 1988 (as of June 30, 1988), the number of hospitals which have their own cardiac surgery capability that are referring patients to both VA and non-VA sources for such surgery and the number of such referrals and their average cost by VA Region.

10. For FY 1987 and FY 1988 (as of June 30, 1988), the mean and median vacancy rates for each of the following personnel categories: Psychiatrists, radiologists, anesthesiologists, registered nurses, licensed practical nurses, pharmacists, occupational therapists, physical therapists, and respiratory therapists.

11. An estimate of the dollar reductions in inventories for drugs, medical supplies, and prosthetics during FY 1988 (as of June 30, 1988), and the number of times facilities in your region have been depleted of critical items or medications or have experienced critical shortages of these items or medications during FY 1988.

12. The current level of funds available to support contract community nursing home care payments for the balance of FY 1988 and the projected amount that will be available in FY 1989.

13. For FY 1988 (as of June 30, 1988), the rate of surgical postponements and of cancellations due to staff shortages and an estimate of the average delay involved for postponements and what proportion of the postponements involved more than one postponement for a particular veteran.

The Committee appreciates your appearing at the hearing so as to respond to questions regarding the VA's capability to meet veterans' health-care needs during the remainder of FY 88 and in FY 89. If you have any questions or would like additional information, please contact Sandi Isaacson or Kristine Hardy of the Committee staff at (202) 224-9126 (FTS 224-9126).

With best wishes,

Sincerely,

Alan Cranston
Chairman

The attached letter was sent to Mr. Bob Lindsey and the following 3 Regional Directors:

Mr. Donald Thompson
Director
Veterans' Administration Regional Office
5700 S.W. 34th Street, Suite 1120
Gainesville, Florida 32608

Mr. Albert Washko
Director
Veterans' Administration Regional Office
113 Hollin Avenue
Albany, New York 12208

Mr. Albert Zamberlan
Director
Veterans' Administration Regional Office
Post Office Box 1407
Ann Arbor, Michigan 48106

Department of Medicine
and Surgery
Western Region

211 Main Street
San Francisco CA 94105

Veterans
Administration

September 9, 1988

In Reply Refer To: 10BA6

Honorable Alan Cranston
Chairman, Committee on Veterans' Affairs
United States Senate
Washington, DC 20510-6375

Dear Senator Cranston:

The enclosed is in response to your letter of August 18 regarding the VA's capability to meet veterans' health-care needs during the remainder of FY-88 and in FY-89.

Sincerely yours,

R. E. Lindsey Jr.

R. E. LINDSEY, JR.
Regional Director
Western Region

Enclosure

Western Region

QUESTION 1: The projected (a) costs for the remainder of FY 1988 and for FY 1989 resulting from the enactment of Public Law 100-322 for (1) the increases in total reimbursements and administrative costs for the beneficiary travel program (and the annual totals for each), (2) registered nurse Saturday premium pay, (3) State home per diem increases, and (4) outpatient care for those for whom care was mandated in the new law, and (b) funding specifically provided to your region for these costs in FY 1988 and projected to be provided for FY 1989.

ANSWER:

			FY88	FY89
			(In Thousands)	
a.	(1)	Beneficiary Travel	2,830	6,040
	(2)	Registered Nurse Saturday Premium Pay	976	2,800
	(3)	State Home per diem	1,150	2,232
	(4)	Outpatient Care	819	3,369

b. The funding for all of the mandatory items in PL 100-322 were included in a supplemental appropriation in FY88. It is unknown, at this time, what funding will be provided in FY89.

QUESTION 2: The current FY 1988 (as of June 30, 1988) and projected remainder of FY 1988 and all of FY 1989 (a) costs for the payment of (1) special salary rates (2) unfunded expenses for special drugs and other care for AIDS patients and for AIDS research, and (3) educational and training expenses resulting from the enactment of Public Law 100-322, related to the care and treatment of AIDS patients, and (b) funding specifically provided to your region for these costs in FY 1988 and projected to be provided for FY 1989.

ANSWER:

	FY88	FY89
	(In thousands)	
Special Salary Rates	40,284	50,000
AZT	1,300	1,600
Other Care for AIDS Patients	16,500	21,600
Education and Training	188	1,000
Funding Provided	36,149	Unknown

Western Region

QUESTION 3: For FY 1988 (as of June 30, 1988), for the remainder of FY 1988, and for FY1989 the (a) costs of implementing universal precautions as recommended by the Center for Disease Control in Atlanta, Georgia, and required by the Occupational Safety and Health Administration for the purpose of protecting VA health-care workers against infectious diseases, and (b) funding specifically provided to your region for these costs in FY 1988 and projected for FY 1989.

ANSWER:

	FY88	FY89
	(In Thousands)	
Universal Precautions	3,400	3,700

No funding has been specifically provided for these costs in either FY88 or FY89

QUESTION 4: The total amount of funds shifted in FY 1988 (as of June 30, 1988), projected to be shifted for the rest of FY 1988, and projected to be shifted in FY 1989 from all non-recurring accounts, listed separately, to cover current and anticipated operations needs (please describe them).

ANSWER:

Non-recurring dollars converted for recurring needs in:

	FY88	FY89
(a) As of 6/30/88		
.19 Replacement Equip.	$3,043,928	$2,486,471
.20 Additional Equip.	$1,721,567	$1,257,375
.23 NRM	$7,723,524	$7,158,211
.21 Contract Hosp.	$133,000	$2,070,605
.22 State Homes	$60,000	0
.27 Fee Medical	$1,065,400	$1,175,000
.28 Fee Dental	$98,000	$47,000
.900 ADP	0	$25,000
(b) Add amount expected 4th QTR		
.19 Replacement Equip.	$157,570	
.20 Additional Equip.	$1,740	
.23 NRM	$393,312	
.21 Contract Hosp.	$0	
.22 State Homes	$0	
.27 Fee Medical	$391,000	
.28 Fee Dental	$0	
.900 ADP	$0	
TOTAL	$14,789,041	$14,249,644

Western Region

QUESTION 5: As of September 30, 1987, and June 30, 1988, the total number of beds, broken down by the number of (a) critical care beds, (b) acute medical/surgical beds, (c) acute psychiatric beds, (d) .long-term psychiatric beds, and (e) intermediate and nursing home care beds currently not available for patient admissions. Please break down the data according to the following reasons: (1) staffing shortages due to (A) recruitment difficulties, and (B) lack of funds, (2) lack of other operating funds to support available beds, (3) then current construction or renovation projects, (4) decreased demand for beds, and (5) other reasons (please specify).

ANSWER:

Beds out of service in the Western Region as of June 30, 1988:

Category	Number of Beds
Blind Rehab	17
CCU	4
Domiciliary	65
Intensive Care	12
Intermediate Medicine	67
Medicine	612
Neurology	47
Neurosurgery	0
Nursing Home Care	60
Psychiatry	213
Rehabilitation	87
Spinal Cord Injury	30
Surgery	506
Telemetry	3
Unspecified	26
TOTAL	**1749**

Reasons beds out of service	Number of Beds
Nursing/Recruit	264
Demand	101
Construct/Renovate	611
Lack Funds	211
Other Staff/Recruit	41
Space/Other	207
Not Defined	314
TOTAL	**1749**

Western Region

QUESTION 6: As of January 29, 1988, and June 30, 1988, the median and average waiting times for non-emergent outpatient appointments in each of the following clinics: general medicine, general surgery, orthopedic, opthalmology, cardiology, urology, mental hygiene, and substance abuse.

ANSWER: The following data represent the low and high range of waiting times in days and the average waiting times in days for the clinics requested:

CLINIC CATEGORY	REPORTING PERIOD	RANGE IN DAYS	AVERAGE WAIT IN DAYS
General Medicine	1/29/88	0-335	36.32
	6/30/88	0-334	37.83
General Surgery	1/29/88	3-124	21.6
	6/30/88	5-68	21.25
Orthopedics	1/29/88	0-83	39.56
	6/30/88	0-97	44.44
Ophthalmology	1/29/88	2-224	83.59
	6/30/88	5-876	84.94
Cardiology	1/29/88	0-92	40.79
	6/30/88	0-120	47.79
Urology	1/29/88	3-199	49.7
	6/30/88	0-165	61.14
Mental	1/29/88	0-177	17
	6/30/88	0-66	14.91
Substance	1/29/88	0-52	6.65
	6/30/88	0-52	6.71

Western Region

QUESTION 7: As of January 29, 1988, and June 30, 1988, the median and average waiting times for non-emergent inpatient admissions to general medicine, general surgery, orthopedics, urology, acute psychiatry, long-term psychiatry, PTSD in-patient units, substance abuse treatment units, and intermediate and nursing home care beds.

ANSWER: The following data are the average waiting times in days for non-emergent inpatient admissions in the bed categories requested:

BED CATEGORY	REPORTING PERIOD	AVE WAITING TIME IN DAYS
General Medicine	1/29/88	1.41
	6/30/88	1.18
General Surgery	1/29/88	6.27
	6/30/88	8.27
Orthopedics	1/29/88	12.77
	6/30/88	17.38
Urology	1/29/88	5.93
	6/30/88	5.43
Alcohol/Drug	1/29/88	10.73
	6/30/88	10.31
Acute/LT Psych	1/29/88	2.27
	6/30/88	1.46
IM & NHC	1/29/88	17.54
	6/30/88	20.79
PTSD	1/29/88	31.57
	6/30/88	30.67

Western Region

QUESTION 8: As of January 29, 1988, and June 30, 1988, the median and average waiting times for admissions for non-emergent cardiac surgery, orthopedic surgeries requiring protheses, and intraocular lens implants.

ANSWER: The following data are the average waiting times in days for non-emergent admissions for the programs requested:

CATEGORY	REPORTING PERIOD	AVE. WAITING TIME IN DAYS
Non-emergent	1/29/88	15.67
Cardiac Surgery	6/30/88	10.17
Orthopedic Surgery	1/29/88	50.
Requiring Prothesis	6/30/88	45.44
Intraocular lens	1/29/88	38.11
Implants	6/30/88	30.22

QUESTION 9: For FY 1987 and FY 1988 (as of June 30, 1988), the number of hospitals which have their own cardiac surgery capability that are referring patients to both VA and non-VA sources for such surgery and the number of such referrals and their average cost by VA Region.

ANSWER: Only two facilities have made cardiac surgery referrals in either 1987 or 1988, VAMC San Diego and VAMC Seattle.

At VAMC San Diego, one patient was referred to a non-VA program during the current fiscal year. The cost was $75,000.

At VAMC Seattle, 107 patients were referred to the University of Washington in FY87 with an average cost of $11,259. In FYTD, 72 patients have been referred, with an average cost of $13,300.

Western Region

QUESTION 10: For FY 1987 and FY 1988 (as of June 30 1988), the means and median vacancy rates for each of the following personnel categories: Psychiatrists, radiologists, anesthesiologists, registered nurses, licensed practical nurses, pharmacists, occupational therapists, physical therapists, and respiratory therapists.

ANSWER:

Category	Average Vacancy Rates Percent		Vacancy Rates Range Percent	
	FY 87	FY 88	FY 87	FY 88
Psychiatrist	11.52	16.05	0-100	0-100
Radiologist	11.14	19.98	0-100	-17 -100
Anesthesiologist	3.42	4.41	0-46	0-50
R.N.	4.53	5.67	0-15	0-18
L.P.N.	5.76	5.50	-32-32	-10-32
Pharmacist	6.81	9.60	0-54	0-46
O.T.	13.85	10.74	0-100	0-100
P.T.	17.14	12.59	0-100	0-100
R.T.	12.01	7.71	0-67	0-40

QUESTION 11: An estimate of the dollar reductions in inventories for drugs, medical supplies, and prosthetics during FY 1988 (as of June 30, 1988), and the number of times facilities in your region have been depleted of critical items or medications or have experienced critical shortages of these items or medications during FY 1988.

ANSWER:

CATEGORY	DOLLAR REDUCTION FY88
Drugs	4,171,760
Medical Supplies	1,964,500
Prosthetics	654,400
TOTAL	6,790.660

Several facilities indicated that they were depleted of critical items or medications or experienced critical shortages of these items or medications during FY88.

Western Region

QUESTION 12: The current level of funds available to support contract community nursing home care payments for the balance of FY 1988 and the projected amount that will be available in FY 1989.

ANSWER: Funds available to support contract community nursing home payments in FY88 (as of 8/31/88) are $44,593,133.00 and in FY89 are $48,430,824.

QUESTION 13: For FY 1988 (as of June 30, 1988), the rate of surgical postponements and of cancellations due to staff shortages and an estimate of the average delay involved for postponements and what proportion of the postponements involved more than one postponement for a particular veteran.

ANSWER:

Rate of surgical postponements/ cancellation	14 Facilities were less than 5% 4 Facilities were 5%-10% 1 Facility was 23% 1 Facility was 20% in elective orthopedics
Average delay	Range from 2 days to 3-6 months
Proportion of postponements involving more than one postponement for a particular veteran.	6 Facilities responded less than 5% 2 Facilities responded less than 10% 2 Facilities responded less than 20% 10 Facilities responded 0

**Department of Medicine
and Surgery
Western Region**

211 Main Street
San Francisco CA 94105

**Veterans
Administration**

September 13, 1988

In Reply Refer To: 10BA60M

Honorable Alan Cranston
Chairman, Committee on Veterans' Affairs
United States Senate
Washington, DC 20510-6375

Dear Senator Cranston:

Please find attached items, that were requested at the Senate Veterans' Affairs Committee hearings on September 9, 1988.

Sincerely yours,

R. E. LINDSEY, JR.
Regional Director
Western Region

Enclosure

"America is #1—Thanks to our Veterans"

FINANCIAL MANAGERS'SHORTFALL REPORT
FIELD IMPACT 9/12/88

	1% PROD FY 88 & PRIOR	GS 11/15 FY 86	SUP INV REDUCTION	GRAMM-RUD TDA'S 3/86	WORKLOAD REDUC FY 86	WORKLOAD RESTOR FY 87	BEN TRAVL REDUC FY 87	BEN TRAVL RESTOR FY 88	VEHICLE REDUC FY 88	W/R CONVERTED FY 88	WIGS FY 88	DHCP/CALM FY 88	SPEC SAL ABSORB FY 86-88	INVENTORY SPENT DOWN	TOTAL
MED.DIST.25															
600 LONG BEACH	$1,679,155	$34,933	$284,924	$1,072,262	$7,007,338	($5,197,285)	$374,609	($199,610)	$17,952	$0	$689,276	$79,829	$113,864	$0	$5,957,247
605 LOMA LINDA	$798,279	$13,758	$112,280	$492,943	$2,114,023	($1,567,953)	$589,573	($314,153)	$10,237	$546,940	$311,571	$34,806	$189,037	$1,070,000	$4,401,341
664 SAN DIEGO	$872,769	$19,558	$162,646	$452,881	$3,682,618	($2,731,367)	$940,236	($501,002)	$7,960	$1,249,281	$433,265	$40,490	$25,747	$1,030,000	$5,685,082
665 SEPULVEDA	$961,406	$22,939	$133,288	$447,042	$4,668,353	($3,462,479)	$279,310	($148,830)	$14,032	$1,670,000	$320,000	$41,980	$127,255	$250,000	$5,324,296
691 WEST LA	$2,040,522	$90,219	$321,300	$1,277,086	$10,886,723	($9,074,592)	$909,248	($484,490)	$68,874	$0	$891,043	$93,630	$315,916	$0	$7,335,479
752 LA OPC	$212,480	$4,720	$11,520	$136,641	$1,754,682	($1,301,433)	$295,728	($157,578)	[illegible]	$0	$50,150	$9,828	$17,742	$0	$1,043,540
758 LAS VEGAS	$85,304	$1,475	$16,677	$50,465	$282,999	($209,898)	$97,007	($51,690)	$962	$0	$0	$3,420	$0	$365,000	$641,721
MED.DIST.25	$6,649,915	$187,602	$1,042,635	$3,929,320	$30,396,736	($23,545,007)	$3,485,711	($1,857,353)	$129,077	$3,466,221	$2,695,305	$303,983	$789,561	$2,715,000	$30,388,706
MED.DIST 26															
358 MANILA	$27,002	$652	$2,322	$7,408	$14,442	($10,712)	$68,535	($34,638)	$0	$0	$0	$542	$0	$0	$75,553
359 HONOLULU	$34,903	$1,818	$8,655	$35,069	$317,622	($235,578)	$144,323	($69,962)	$1,523	$0	$20,482	$3,214	$0	$0	$262,069
570 FRESNO	$400,832	$8,759	$54,126	$199,205	$1,959,959	($1,453,685)	$318,743	($119,616)	$1,878	$1,844,348	$188,011	$18,576	$0	$337,000	$3,758,136
599 LIVERMORE	$296,330	$6,668	$41,975	$136,445	$724,179	($537,118)	$225,187	($86,470)	$9,034	$679,021	$104,376	$12,846	$99,688	$361,660	$2,073,821
612 MARTINEZ	$585,350	$15,570	$124,708	$434,674	$3,288,801	($2,439,276)	$809,004	($351,790)	$12,329	$860,000	$247,000	$32,804	$209,551	$400,000	$4,228,725
640 PALO ALTO	$1,373,504	$37,115	$177,919	$919,950	$4,650,988	($4,449,599)	$794,136	($363,797)	$25,054	$1,600,514	$675,222	$68,796	$478,835	$0	$5,988,637
654 RENO	$380,799	$10,565	$57,206	$178,591	$2,132,229	($1,581,457)	$377,125	($161,903)	$3,456	$512,876	$168,988	$16,842	$4,170	$447,000	$2,546,487
662 SAN FRAN	$791,060	$23,934	$141,668	$534,893	$4,258,237	($3,158,299)	$889,143	($301,109)	$11,803	$990,582	$323,143	$40,091	$199,589	$397,000	$5,141,735
MED. DIST. 26	$3,889,780	$105,081	$608,579	$2,446,235	$17,346,457	($13,865,724)	$3,626,196	($1,489,285)	$65,077	$6,487,341	$1,727,222	$193,711	$991,833	$1,942,660	$24,075,163
MED. DIST 27															
363 ANCHORAGE	$21,007	$1,486	$276	$21,321	$165,494	($122,746)	$332,556	($262,367)	$4,412	$1,024,400	$23,097	$3,499	$0	$0	$1,212,435
505 AM LAKE	$443,980	$9,299	$42,922	$251,043	$642,023	($476,183)	$283,830	($141,258)	$18,504	$789,949	$211,281	$18,021	$7,345	$0	$2,100,756
531 BOISE	$297,887	$6,822	$50,312	$148,357	$1,055,618	($782,943)	$308,173	($184,155)	$3,276	$585,200	$72,440	$14,347	$19,073	$490,000	$2,084,407
648 PORTLAND	$1,115,717	$21,477	$171,051	$503,969	$3,695,058	($2,740,594)	$1,211,555	($750,703)	$19,788	$850,500	$526,906	$52,488	$244,090	$740,000	$5,661,302
653 ROSEBURG	$361,370	$5,864	$38,330	$150,327	$1,237,310	($917,703)	$126,260	($47,230)	$11,820	$307,375	$153,504	$14,347	$33,134	$80,000	$1,554,708
663 SEATTLE	$852,310	$19,534	$123,826	$464,046	$2,644,063	($1,961,080)	$1,135,002	($591,030)	$8,783	$1,043,149	$390,000	$44,615	$66,638	$725,000	$4,964,856
668 SPOKANE	$267,192	$4,336	$33,712	$147,273	$643,041	($476,938)	$166,849	($108,110)	$3,614	$215,906	$102,673	$11,897	$2,609	$70,000	$1,084,054
687 WALLA WALLA	$202,543	$3,101	$21,760	$79,846	$812,628	($602,719)	$114,195	($38,131)	$2,757	$19,000	$72,935	$7,173	$0	$0	$695,088
692 WHITE CITY	$123,798	$3,300	$23,416	$90,442	$252,322	($187,145)	$40,275	($43,547)	$9,359	$0	$92,696	$8,573	$3,271	$28,000	$444,760
MED. DIST 27	$3,685,804	$75,219	$505,605	$1,856,624	$11,147,557	($8,268,051)	$3,718,695	($2,166,531)	$82,313	$4,835,479	$1,645,532	$174,960	$376,160	$2,133,000	$19,802,366
TOTAL REG. 6	$14,225,499	$367,902	$2,156,819	$8,232,179	$58,890,750	($45,678,782)	$10,830,602	($5,513,169)	$276,467	$14,789,041	$6,068,059	$672,654	$2,157,554	$6,790,660	$74,266,235

Western Region RN Vacancy and Turnover Rate as of 9-9-88

Facility	FTE Vacancies	Turnover rate
MD 25		
Las Vegas OPC	0	14.28%
Loma Linda	32.5	25.20%
Long Beach	47	16%
LA OPC	0	0%
San Diego	29.23	13.40%
Sepulveda	9	20%
West L.A.	111.3	17.70%
MD 26		
Fresno	10.4	24%
Honolulu OPC	1	0%
Livermore	4.8	22%
Manila OPC	0	0%
Martinez	8	22.70%
Palo Alto	28.5	22%
Reno	9.2	48%
San Francisco	65	26%
MD 27		
American Lake	7.6	16%
Anchorage OPC	2	0%
Boise	12.2	13.80%
Portland	16.3	6.80%
Roseburg	4	16%
Seattle	26.6	32.50%
Spokane	7	14%
Walla Walla	0	21%
White City	0	19%
Region Totals	431.63	17.09%

Southeastern Region

5700 S.W. 34th Street
Gainesville FL 32608

Veterans Administration

September 9, 1988

In Reply Refer To

Senator Alan Cranston
Chairman, Committee on Veterans' Affairs
Washington, DC 20510-6375

Dear Senator Cranston:

In response to your letter of August 18, 1988 in which you requested information about VA medical facilities in the Southeast Region, the attached is provided. I have listed your 13 questions and the appropriate response for each as requested.

I appreciate the opportunity to respond to your questions.

Donald B. Thompson

DONALD B. THOMPSON
Regional Director

SENATE VETERANS' AFFAIRS
COMMITTEE HEARING
SEPTEMBER 9, 1988

1. QUESTION: The projected (a) costs for the remainder of FY 1988 and for FY 1989 resulting from the enactment of Public Law 100-322 for: (1) the increases in total reimbursements and administrative costs for the beneficiary travel program (and the annual totals for each), (2) registered nurse Saturday premium pay; (3) State home per diem increases; and (4) outpatient care for those for whom care was mandated in the new law; and (b) funding specifically provided to your region for these costs in FY 1988 and projected to be provided for FY 1989.

RESPONSE: I estimate the FY 1988 4th quarter cost of Public Law 100-322 to be $3,415,773 in the four major areas of beneficiary travel, RN Saturday premium pay, increases mandated in state home per diem rates, and outpatient care made mandatory under the new law. The Southeast Region has been funded $3,790,121 in the 4th quarter as a result of actions taken by VACO preceding the actual passage of the FY88 Supplemental Appropriation.

In FY89, we anticipate the impact of P.L. 100-322 to be $13,114,886. Thus far, only $724,872 in state home per diem increases have been received. No apportionment has yet been received from OMB due to the recent passage of the FY89 Appropriation. The specific breakdowns you requested concerning the component projected costs of PL 100-322 are as follows: (Please note that only three VAMCs in the Southeast Region support State Veterans' Homes).

	4th QUARTER FY88		FY89	
	Projected Cost	Funding Available	Projected Cost	Funding Available
1. Beneficiary Travel				
Reimbursements:	$1,412,986	$1,443,124	$6,043,491	-0- *
Administrative costs:	$80,203	$11,262	$341,646	-0- *
2. RN Saturday Premium Pay:	$839,714	$882,464	$3,028,926	-0- *
3. State Home Increases:	$282,286	$437,674	$735,619	$724,872 **

4. Outpatient Care to
New Entitled Veterans:
$746,584 | $1,015,597 $2,965,204 | -0- *

* = Indicates areas where Region has not received their apportionment of the FY89 Appropriation.

** = Represents increase in FY89 Target Allowance over FY 88.

2. QUESTION: The current **FY 1988** (as of June 30, 1988), **projected remainder of FY 1988**, and **all of FY 1989** (a) **costs for** the payment of (1) **special salary rates**, (2) **unfunded expenses for special drugs** and other care for **AIDS patients** and for **AIDS research**, and (3) **educational and training expenses** resulting from the **enactment of Public Law 100-322, related to the care and treatment of AIDS patients**, and (b) **funding specifically provided to your region** for these costs in **FY 1988 and projected** to be provided for **FY 1989.**

RESPONSE: Special salary rates through June 30, 1988 in the Region totaled $2,299,605, and the projected cost for the fourth quarter of FY 88 is $1,071,578. The funding centrally provided to region facilities to support these costs was $1,035,946 through the first three quarters, and is projected at $567,912 for the fourth quarter of FY 88. In FY 89, Southeast Region facilities project special salary costs of $5,981,790 with $2,538,161 currently available to fund these requirements.

Region facilities conservatively estimate that $3,509,733 has been utilized through June 30, 1988 for unfunded specialty drugs related to the treatment of AIDS and for AIDS research. Estimates for the fourth quarter of FY 88 approximate $1.23 million. I'm sure that facilities did not report the cost of hospitalization for these patients which, in this Region, is estimated to exceed $11.0 million in FY 88 based on the preliminary results of a national VA study. This study, which is based on the current number of AIDS cases being treated, estimates the FY 89 costs for the Southeast Region as follows:

Specialty Drugs	$ 1,100,000
AIDS Treatment	15,000,000
Education and Training	1,000,000
Targeted Testing	1,100,000
TOTAL	$ 18,200,000

To date in FY 88, $847,000 in nonrecurring dollars, specifically designated for AIDS, have been provided to Southeast Region facilities. The funding provided through the FY 88 Supplemental is being utilized in the development of the National AIDS Training Program through our network of Regional Continuing Education Centers. The Region's share of any FY 89 funding that is made available through the FY 89 Appropriations Bill has not been determined. If the distribution of these funds are limited however, to the 16 hospitals cited in the Bill, many facilities will be required to continue to absorb the costs of treating their AIDS caseload.

3. QUESTION: For FY 1988 (as of June 30, 1988), for the remainder of FY 1988, and for FY 1989 the (a) costs of implementing universal precautions as recommended.by the Center for Disease Control in Atlanta, Georgia, and required by the Occupational Safety and Health Administration for the purpose of protecting VA healthcare workers against infectious diseases, and (b) funding specifically provided to your region for these costs in FY 1988 and projected to be provided for FY 1989.

RESPONSE: Southeast Region facilities have estimated the FY 88 cost of implementing universal precautions at approximately $1.72 million dollars through June 30, 1988, with an additional $898,000 projected for the fourth quarter. The nationwide study mentioned earlier in our response to Question No. 2, estimates the FY 89 cost to approximate $3.7 million for the Region.

To date, no specific funding has been provided in FY 88 to offset the costs of universal precautions, and, to my knowledge, no specific funding is available through the FY 89 Appropriations Bill in this area.

4. QUESTION: What are the total amount of funds shifted in FY88 (as of June 30, 1988), projected to be shifted for the rest of FY88, and projected to be shifted in FY 1989 from all nonrecurring accounts, listed separately, to cover current and anticipated operational needs?

RESPONSE: The following amounts of nonrecurring funds, by analysis account, were shifted as of June 30, 1988, projected to be shifted for the rest of FY88, and projected to be shifted in FY89 for the Southeastern Region:

Analysis Account	6/30/88	Rest of FY88	Projected FY89
.19 Replacement Equip.	$1,096,806	$ 236,460	$ 2,951,752
.20 Additional Equip.	586,593	127,860	(included in .19)
.23 NRM	3,517,158	761,180	5,113,517
.21 Contract Hosp.	-0-	-0-	1,367,503
.24 Comm. Nurs. Home	-0-	-0-	4,213,063
.27 Fee Medical	-0-	-0-	1,636,807
.28 Fee Dental	-0-	-0-	101,256
TOTAL	$5,200,557	$1,125,500	$15,383,898

5. QUESTION:	As of September 30, 1987, and June 30, 1988, the total number of beds, broken down by the number of (a) critical care beds, (b) acute medical / surgical beds, (c) acute psychiatric beds, (d) long-term psychiatric beds, and (e) intermediate and nursing home beds currently not available for patient admissions. Please breakdown the data according to the following reasons: (1) staffing shortages due to (A) recruitment difficulties and (B) lack of funds, (2) lack of other operating funds to support available beds, (3) current construction or renovation projects, (4) decreased demand for beds and (5) other reasons (please specify).
RESPONSE:	On September 30, 1987, a total of 1308 beds within the Southeast Region were unavailable for patient admissions. Of this total, 53.44%, or 699 beds, were unavailable due to ongoing construction or renovation. Two hundred and thirty-eight (238) beds were temporarily closed due to lack of demand at two of the Region's twenty-one facilities, 208 of which were in the area of long-term psychiatry. Two facilities reported 175 beds out of service due to lack of operating funds, but I must add that in both cases these beds had not been in operation for several years due to inadequate activation resources following major construction. Only one facility reported beds out of service due to inadequate funds to support staff and this was primarily due to a loss of staffing associated with Resource Allocation Model reductions at that hospital. Beds temporarily closed due to staff recruitment difficulties totaled 147 on September 30, 1987.

By June 30, 1988, unavailable beds within the Southeast Region increased by 74 from 1308 to 1382. While closures due to lack of demand had decreased, the largest single increase in temporary bed closures was from 147 to 346 due to staff recruitment difficulties.

On both dates, a very small percentage of beds were unavailable for "other" reasons. On June 30, 1988, for example, 34 beds at one facility were unavailable due to an air conditioning failure in one of the patient care buildings. Other examples of temporary bed closures include a temporary need to utilize bed space for other functions while activities such as painting and other minor maintenance are performed.

Below is a recap of the unavailable beds within the Southeast Region for September 30, 1987 and June 30, 1988.

AS OF SEPTEMBER 30, 1987

BED CATEGORY	RECRUIT-MENT	STAFFING FUNDS	OPER. FUNDS	CURRENT CONSTR.	DECREASED DEMAND	OTHER
Critical Care	24	0	0	10	0	0
Acute Med/Surg	123	40	175	528	30	9
Acute Psych	0	0	0	0	0	0
Long-term Psych	0	0	0	116	208	0
Intermediate/NHCU	0	0	0	45	0	0
Total by Region	147	40	175	699	238	9
Percent of Total	11.24	3.06	13.38	53.44	18.20	.69
Grand Total Region	1308					

AS OF JUNE 30, 1988

Critical Care	34	0	0	12	0	0
Acute Med/Surg	184	40	169	538	30	11
Acute Psych	50	0	0	11	0	34
Long-term Psych	28	0	0	94	99	0
Intermediate/NHCU	10	0	0	38	0	0
Total by Region	306	40	169	693	129	45
Percent Total	22.14	2.89	12.23	50.14	9.33	3.26
Grand Total Region	1382					

6. QUESTION: As of January 29, 1988, and June 30, 1988, the **median and average waiting times for non-emergent outpatient appointments** in each of the following clinics: General Medicine, General Surgery, Orthopedic, Ophthalmology, Cardiology, Urology, Mental Hygiene, and substance abuse?

RESPONSE: The following table displays the range, median, and average waiting time, in days, for the clinics indicated in Question 6 above:

CLINIC	JANUARY 29, 1988			JUNE 30, 1988		
	RANGE	MEDIAN	AVG.	RANGE	MEDIAN	AVG.
Gen. Medicine	0-198	99	28	0-180	90	29
Gen. Surgery	0- 88	44	13	0- 94	47	18
Orthopedics	2-221	110	47	9-148	74	44
Ophthalmology	2-150	75	24	1-233	116	60
Cardiology	0-207	104	56	1-200	100	75
Urology	0- 82	41	23	1- 81	40	23
Mental Hygiene	0- 27	14	9	0- 49	26	15
Substance Abuse	0- 20	10	7	0- 49	26	12

7. QUESTION: As of January 29, 1988 and June 30, 1988, the **median and average waiting times for nonemergent inpatient admissions** to General Medicine, General Surgery, Orthopedics, Urology, Acute Psychiatry, Long-Term Psychiatry, PTSD inpatient units, substance abuse treatment units, and intermediate and nursing home care beds.

RESPONSE: The following table displays the range, median, and average waiting time, in days, for the services indicated in Question 7 above:

CLINIC	JANUARY 29, 1988			JUNE 30, 1988		
	RANGE	MEDIAN	AVG.	RANGE	MEDIAN	AVG.
Gen. Medicine	0- 31	16	4	0- 32	16	3
Gen. Surgery	0- 40	20	6	0- 41	22	7
Orthopedics	9- 75	38	9	0- 75	38	9
Urology	0- 27	14	5	0- 27	20	6
Acute & long-term Psychiatry	0-160	80	16	0-160	80	14
PTSD Inpt Units	1- 36	18	11	1- 93	46	26
Substance Abuse	0- 17	9	4	0- 27	14	4
Intermediate & Nursing Home	0-180	90	29	0-180	90	30

8. QUESTION: As of January 29, 1988 and June 30, 1988, the median and average waiting time for admission for nonemergent Cardiac Surgery, Orthopedic surgeries requiring prostheses, and intraocular lens implants?

RESPONSE: The following table displays the range, median, and average waiting times, in days, for the clinics indicated in Question 8 above:

	JANUARY 29, 1988			JUNE 30, 1988		
SERVICE	RANGE	MEDIAN	AVG.	RANGE	MEDIAN	AVG.
Cardiac Surgery	1-133	67	24	0-134	67	31
Orthopedic Surgery w/Prosthesis	0- 75	38	12	0- 75	38	12
Intraocular Surgery	0- 54	27	14	0- 55	28	14

9. QUESTION: For FY 1987 and FY 1988 (as of June 30, 1988), the number of hospitals which have their own cardiac surgery capability that are referring patients to both VA and non-VA sources for such surgery, and the number of referrals and their average cost by VA Region.

RESPONSE: In response to Question No. 9, the Southeastern Region queried its facilities having cardiac surgery capability to determine the answers to the following questions for both FY 87 and 88:

1) Number of patients referred to another VA facility at no cost to the VAMC.

2) Number of patients referred to another VA facility at a cost to the VAMC.

3) Number of patients referred to a non-VA facility at no cost to the VAMC.

4) Number of patients referred to a non-VA facility at a cost to the VAMC.

In FY 1987 there were three VAMCs which referred patients for cardiac surgery to both VA and non-VA sources. The total number of cases referred was 180. Of the 180 referrals in FY 1987, 169 of these were at VAMC Atlanta. This was due to the fact that Atlanta's Cardiac Surgery Program did not open until April 1987, and did not become fully operational until the end of that fiscal year. Therefore, even though VAMC Atlanta is showing a Cardiac Surgery Program in FY 1987, it was not operational for the major portion of that year. Prior to activation, all emergent patients, and patients who were unstable for transfer, were referred to a local community hospital. All others were referred to other VAMCs. Of the 180 referrals in FY87, 89 cases were referred to non-VA facilities. The average cost for each procedure, and any related travel, was $9,729.

In FY 1988 there were five VAMCs which referred patients for cardiac surgery to both VA and non-VA sources. The total number of cases referred was 95. Of the 95 total referrals in FY 1988, 75 of these were at VAMC Atlanta. VAMC Atlanta's open heart program is currently performing four open heart surgeries per week. When an emergency open heart is needed, attempts are made to perform the surgery at VAMC Atlanta. If this is not possible due to lack of availability of the cardiac surgery team, space, etc., the patient must be referred to a community hospital. This has occurred only twice during FY 1988. All other patients referred to a community hospital in FY88 were for Angioplasty which cannot presently be performed at VAMC Atlanta. Of the 95 total referrals in FY88, the number referred to non-VA facilities was 67 at an average cost of $5,419 for the procedure, and any related travel. The reason the procedure cost for non-VA referrals was so much less in FY 88 as compared to FY 87 was because over 83% of these referrals were for Angioplasty as opposed to Coronary Artery Bypass Grafts (CABG). Only 8 of the 67 referred patients mentioned above were for CABGs, and these were done at an average cost of $23,055 each.

10. QUESTION: **For FY 1987 and FY 1988 (as of June 30, 1988), the mean and median vacancy rates for each of the following personnel categories: Psychiatrists, Radiologists, Anesthesiologists, Registered Nurses, Licensed Practical Nurses, Pharmacists, Occupational Therapists, Physical Therapists, and Respiratory Therapists.**

RESPONSE: Reported vacancies in the above occupational categories for September 30, 1987 and June 30, 1988 are displayed below for the Southeast Region Twenty-one facilities are used in calculating the Mean. In all categories, some facilities reported no vacancies, therefore the heading "Range Zero to:" is displayed to report the highest number of vacancies reported by any one facility.

AS OF SEPTEMBER 30, 1987

OCCUPATION	TOTAL AUTH. AT VAMCs	VACANT POSITIONS	RANGE ZERO TO:	MEAN*	MEDIAN*
Psychiatrists	265	42	7	1.58	1.60
Radiologists	122	19	4	1.56	1.10
Anesthesiologists	56	11	3	1.96	-0-
Registered Nurses	5415	253	30	0.47	0.41
Lic. Pract. Nurses	2218	130	30	0.58	0.24
Pharmacists	576	59	11	1.02	0.48
Occupational Thera.	108	18	5	1.70	-0-
Physical Thera.	104	27	6	2.60	-0-
Respiratory Thera.	236	23	6	0.98	0.70
		AS OF JUNE 30, 1988			
Psychiatrists	264	29	8	1.86	1.40
Radiologists	127	20	3	1.60	1.30
Anesthesiologists	52	12	4	2.30	-0-
Registered Nurses	5470	329	29	0.47	0.41
Lic. Pract. Nurses	2261	161	24	0.70	0.60
Pharmacists	580	51	10	0.88	0.6
Occupational Thera.	112	14	4	1.25	-0-
Physical Thera.	102	21	4	2.06	-0-
Respiratory Thera.	247	18	7	0.73	-0-

*Mean and Median Rate Per 10 Authorized Positions.

11. QUESTION: **An estimate of the dollar reductions in inventories for drugs, medical supplies, and prosthetics during FY 1988 (as of June 30), and the number of times facilities in your region have been depleted of critical items or medications or have experienced critical shortages of these items or medications during FY 1988?**

RESPONSE: The Southeastern Region facilities have reduced inventories for drugs, medical supplies, and prosthetics during FY 1988 to date for a total of $9,790,676. However, to the best of our knowledge, no facility has depleted the inventories to a critical level resulting in critical shortages of these items or medications. If this event had occurred, the facility would have notified the Region office for emergency funding.

12. QUESTION: **The current level of funds available to support contract community nursing home care payments for the balance of FY 1988, and the projected amount that will be available in FY 1989.**

RESPONSE: Cumulative through July, 1988, the total actual contract community nursing home care payments for the Southeastern Region totaled $37,014,810. The total funds available for the months of August and September total $7,456,438. The FY 1989 funds provided for the contract community nursing home care program total $46,179,564. These funds are expected to meet the per diem costs to support an ADNC of 1,796.0 as compared to an ADNC of 1,795.7 in FY 88.

13. QUESTION: For FY 1988 (as of June 30, 1988), the rate of surgical postponements and of cancellations due to staff shortages and an estimate of the average delay involved for postponements, and what proportion of the postponements involved more than one postponement for a particular veteran?

RESPONSE: Medical centers do not keep separate records on surgical procedure cancellations due to a lack of staff, either in the surgical suite or the surgical ICU. The following information is provided as a best estimate of the cancellations caused by a lack of staff.

> As of June 30, 1988, the Southeastern Region had scheduled a total of 36,849 surgical inpatient procedures. One facility did not schedule 325 procedures due to staff shortages in the operating room. Of these total scheduled surgical procedures, 730 cases were postponed with 66 patients having multiple postponements. Of the 730 cases postponed, 60 cases were due to a temporary closure of the operating room at Memphis because of a lack of Anesthesiologists. The average delay involved per postponement approximates 8 days, not considering the 60 cases rescheduled because of Anesthesiology problems.
>
> As of June 30, 1988, the Southeastern Region had scheduled a total of 40,588 outpatient surgical procedures with 51 being postponed due to lack of staff with an average delay per postponement of 23 days.

Southeastern Region
5700 S.W. 34th Street
Gainesville FL 32608

Veterans Administration

September 19, 1988

In Reply Refer To:

Senator Alan Cranston
Chairman, Committee on Veterans' Affairs
Washington, DC 20510-6375

Dear Senator Cranston:

I received your letter of September 12, 1988, regarding follow-up questions to testimony given at the Committees' Hearing last week, upon arrival back in my Gainesville office on Friday afternoon, September 16.

I apologize for not being able to meet your Monday response date. I appreciate the opportunity to respond to your questions.

Donald B. Thompson
DONALD B. THOMPSON
Regional Director

Follow-up Questions Submitted by Senator Alan Cranston
to Mr. Donald B. Thompson
in Connection with the Committee on Veterans' Affairs
September 9, 1988, Hearing

September 12, 1988

Question #1: On Page 1 of the Chief Medical Director's Task Force Report, it is recommended that the RAM as a resource-redistribution tool be discontinued. What is the rationale behind this recommendation?

Response: We anticipate the need to reduce current workloads as one of the measures needed to cope with the projected Budget Shortfall in FY 89. Though RAM has been an extremely important and useful management tool, it inherently provides incentives to increase workload within current resources. If workload reductions must be made in FY89 it would be unfair to the field facilities to utilize RAM as a method of resource allocation when we know the field must reduce workloads to balance the financial ledgers. We must remember that RAM has never been a reimbursement Methodology. It only allocates a virtually fixed pool of dollars among the 172 Medical Centers.

Question #2: The Task Force listed a total of 86 options which might be considered to offset the anticipated 1989 shortfall. Are you aware of any facilities in your region which have implemented, in whole or in part, some of these options or have attempted to implement them this fiscal year or are anticipating implementing these options in fiscal year 1989? Please provide details.

Response: The 86 options referenced in your question must first be placed in Context. It represents a list of ideas submitted by Medical Center Directors, Regional, and VACO staff as a brainstorming of options in dealing with the potential shortfalls. These options are later narrowed in the report to 18 having potential for dealing with projected shortfalls.

Several of the options have, in one form or another, been utilized by Field level managers to deal with budget shortfalls or temporary staff shortages in FY88 and prior years. Items such as delay in filling vacant position, consolidation of patients on fewer wards and limiting Community Nursing Home placement (for NSC veterans) to a 90 day or less contract have all been used to various degrees as management tools in making resources stretch.

Most facilities in the Southeast, for example, have been required for many years to control workloads by limiting access to outpatient care, in particular, to veterans on the lower end of the Congressionally mandated priority scale. The report documents, in fact, that the Southeast Region has historically had the lowest percentage of discretionary workload in the nation. Though constrained resources and a growing sunbelt population are the cause of this phenomenon the result creates an inequity in terms of access to care between geographical Regions of the Country. I am gratified that the report recognizes this discrepancy and addresses workload reductions in a way that will accomplish access parity nation wide.

The CMD, his staff and operations staff including the Regional Directors, have spent a great deal of time over the past two months in reviewing the report you reference. Though no final decisions have been made with respect to which recommendations will be implemented these decisions will likely be made in the near future. It would be inappropriate for me to unilaterally implement any of the recommendations until final Department level decisions are made. Based on the current level of appropriations however, it is obvious that a number of the recommendations will require implementation.

Question #3: Please describe those options from the Report that you believe are most feasible to implement in your region and those that would be most disruptive and harmful. You may restrict yourself to the top 18 options, if you wish.

Response: I personally believe that all of the top 18 options recommended by the report are implementable, with some likely to require phasing implementations over 2 or 3 years. Many of the recommended actions such as the deferral of equipment purchases, reprioritization of Maintenance and Repair, use of the Minor Construction appropriation are, at best, short term fixes of a non-recurring nature, that can't be depended upon as long term solutions. Several also are beyond the level of CMD discretion which will ultimately slow our ability to react and implement quickly.

I personally don't believe we can continue to expect VA Medical Centers to operate within our FY 89 budget without reducing Workload and employment expectations. To attempt to do so would place quality of care in jeopardy.

There are very few, if any, recommendations that could be made to deal with shortfalls that are not disruptive to the entire system. We have virtually exhausted options that are less disruptive in nature while dealing with prior year erosions that fall short of actual inflation cost in the health care delivery industry. We have patched the holes by diverting money from capital accounts, and by increased productivity and cost controls. Any financial flexibility that may have at one time existed with the Department has disappeared thru erosion. The report recommendations are tough choices, but several tough choices must be made.

I believe the most reasonable options in Southeast Region are as follows:

- Total elimination of Beneficiary Travel (except inter hospital transfers).
- Return of MEDIPP Contingency Funding to Field facilities.
- Deferral of High/Tech - Joint Sharing procurements.
- Decentralization of Non-VA workloads.
- Reprioritize or eliminating over the counter drugs or required co-payment of drug costs.
- Elimination of Chronic outpatient and Fee for Service Dialysis thru transfer to HCFA.

Question #3 (continued):

Response:

- Relief from Congressional fences on AIDS Funding, Employment ceilings.
- Reduction in transplant workloads.

The most disruptive options to the Southeastern Region are:

- Delay of facility activations.
- Reprioritization and Continued Diversion of capital equipment, Maintenance and Repair, and Construction Accounts.

RESPONSES TO CHAIRMAN CRANSTON'S WRITTEN QUESTIONS
FROM MR. ALBERT WASHKO

Question: 1. The projected (a) costs for the remainder of FY 1988 and FY 1989 resulting from the enactment of Public Law 100-322 for (1) the increases in total reimbursements and administrative costs for the beneficiary travel program (and the annual totals for each), (2) registered nurse Saturday premium pay, (3) state home per diem increases, and (4) outpatient care for those whom care was mandated in the new law, and (b) funding specifically provided to your region for these costs in FY 1988 and projected to be provided for FY 1989.

Answer:

(a) 1. Projected beneficiary travel costs (FY 1988)	
Projected costs prior to PL 100-322	9,371,000
Projected costs of PL 100-322	937,000
Administrative cost of PL 100-322	120,000
TOTAL FY 1988	10,428,000
Projected beneficiary travel costs (FY 1989)	
Projected costs prior to PL 100-322	9,371,000
Projected costs of PL 100-322	3,354,000
Administrative cost of PL 100-322	442,000
TOTAL FY 1989	13,167,000

(a) 2. The projected costs of registered nurse Saturday premium pay from the enactment of PL 100-322 are $1,182,000 for FY 1988 and $3,416,000 for FY 1989.

(a) 3. The increased cost for state home domiciliaries, nursing homes, and hospitals for FY 1988 is $1,334,000 and $1,779,000 for FY 1989.

(a) 4. The projected costs of expanded outpatient eligibility under PL 100-322 is $919,000 for FY 1988 and $3,632,000 for FY 1989.

(b) Additional funding for items related to PL 100-322 has only been received for FY 1988. No funding has been currently received for FY 1989. FY 1988 funding is as follows:

1.	1,299,000	FY 1988 Beneficiary Travel
2.	918,000	FY 1988 Saturday Premium Pay
3.	1,630,000	FY 1988 State Homes
4.	602,000	FY 1988 Outpatient Eligibility

Data Source:

1(a). Facility input

2(a). PAID data in Austin

3(a). Allotment Authority and increased rate amounts

4(a). Facility Input

Question 2. The current FY 1988 (as of June 30, 1988) and projected remainder of FY 1988 and all of FY 1989 (a) costs for the payment of (1) special salary rates, (2) unfunded expenses for special drugs and other care for AIDS patients and for AIDS research, and (3) educational and training expenses resulting from the enactment of Public Law 100-322, related to the care and treatment of AIDS patients, and (b) funding specifically provided to your region for these costs in FY 1988 and projected to be provided for FY 1989.

Answer 2a(1) The VA accounting system cannot provide exact cost data for special salary rates. Therefore the items below are funded amounts from VACO and cost estimates of facility funded special rates.

	FY87	FY88	FY89	
Approved in FY 87	2,983,000	15,895,000	15,895,000	(R)**
Approved in FY 88		16,807,000	22,005,000	(R)
FY 89 Estimate			21,009,000*	(R)
Total VACO Funded	2,983,000	32,702,000	58,909,000	(R)
Facility Funded	511,000	1,231,000	1,539,000*	(R)
Grand Total	3,494,000	33,933	60,448,000	(R)

*FY 89 Estimates of Special Pay based on FY 88 approvals x 1.25

**(R) - RECURRING

Question 2. The current FY 1988 (as of June 30, 1988) and projected remainder of FY 1988 and all of FY 1989 (a) costs for the payment of (1) special salary rates, (2) unfunded expenses for special drugs and other care for AIDS patients and for AIDS research, and (3) educational and training expenses resulting from the enactment of Public Law 100-322, related to the care and treatment of AIDS patients, and (b) funding specifically provided to your region for these costs in FY 1988 and projected to be provided for FY 1989.

Answer 2a(2) The unfunded expenses for special drugs, care for AIDS patients and AIDS research are having a significant impact on the operating funds of VA Medical Centers in the Northeastern Region. It is estimated that Region 1 VAMC's provide from 25 to 28 percent of the AIDS care in the country. A summary of the estimated cost, funding provided and unfunded expenses appears below. Please note that estimated costs are based on preliminary results from a national task force on AIDS chaired by the Director at VAMC New York. Their charge is to develop accurate cost accounting and reimbursement systems for the treatment of AIDS. Additional new drugs and more widespread utilization could inflate these estimates.

Question 2a(2) COST SUMMARY FOR AIDS CARE (FY88 & FY89)

		Estimated Cost	Funded	Unfunded Expenses
Special Drugs (FY88)	(AZT)	$1,800,000	--	
	(Pentamidine)	$ 9,324	--	
	Total -	$1,809,324		$1,809,324 (FY88)
Special Drugs (FY89)	(AZT)	$2,300,000	--	
	(Pentamidine)	$ 145,945	--	
	Total -	$2,445,945		$2,445,945 (FY89)
AIDS Care (FY88)		$23,600,000	$4,800,000 (By CO)(NR)	$18,800,000 (FY88)
(FY89)		$30,900,000	$5,700,000 Approp.Bill(NR)	$25,200,000 (FY89)
AIDS Research (FY89)		Between $1,600,000- $3,000,000	Between $1,600,000- $3,000,000	

Question 2a(3)

		Estimated Cost	Funded	Unfunded Expenses
Education & Training (FY88)		$ 800,000	$268,000 (Supplemental)(NR)	$532,000 (FY88)
(FY89)		$2,300,000 (Vol.test)	--Funding not known	
		$1,014,000 (Educ)		
	Total -	$3,314,000		$3,314,000 (FY89)

	FY88	FY89
Total Region 1 estimated cost:	$26,209,324	$36,659,945
Total funding provided:	5,068,000	5,700,000
Projected unmet costs:	21,141,324	30,959,945

*Note: Totals exclude AIDS research need and funding

Key:
(NR) - Non-recurring

Question 3: For FY 1988 (as of June 30, 1988), for the remainder of FY 1988, and for FY 1989 the (a) costs of implementing universal precautions as recommended by the Centers for Disease Control in Atlanta, Georgia, and required by the Occupational Safety and Health Administration for the purpose of protecting VA health-care workers against infectious diseases, and (b) funding specifically provided to your region for these costs in FY 1988 and projected to be provided for FY 1889.

Answer: There is some difficulty in determining the cost impact of implementing "universal precautions". Although OSHA and the Center for Disease Control guidelines for protecting health-care workers against infectious disease, the interpretation of these guidelines is subject to an individual facility's philosophy of patient care and safety in the workplace. Implementation cost is a function staff education, provision of barrier precautions, use of disposable equipment and clothing and needle and scalpel blade disposal. It is projected that full implementation of "universal precautions" will cost $6,000,000-$7,000,000 annually in Region 1. (Again, assuming that Region 1 treats at least 25% of AIDS patients.

		FY 88 (Costs)	Proj. FY89 (Costs)
3.a.	*Universal Precautions	$6,400,000	$7,000,000

*Note: Projected that Universal Precautions will cost between $6-7,000,000 annually in Region 1.

b. No funding specifically provided for FY88 or FY89.

Question 4: The total amount of funds shifted in FY 1988 (as of June 30, 1988), projected to be shifted for the rest of FY 1988, and projected to be shifted in FY 1989 from all non-recurring accounts, listed separately, to cover current and anticipated operational needs (please describe them).

Answer: Total amount of funds shifted from non-recurring accounts to cover current and anticipated operational needs:

FY 88 (In Millions)

	June 30	4th Qtr. Project	Total FY 88
Replacement Equipment	$1.8		$1.8
Additional (New) Equipment	0.9		0.9
NRM (Projects)	4.7	*-0.2	4.5
TOTAL	$7.3	($0.2)	$7.1

*Note: As of June, funds were shifted from NRM accounts to support other operations due to uncertainty of a supplemental. After supplemental was passed, available funds were shifted back to NRM.

IMPACT: Because of prior year budget reductions without FTEE reduction, we have reached the breaking point of maintaining FTEE in Region 1. Maintaining current services with the FY89 budget level is doubtful. In addition, essential maintenance projects and the basic replacement equipment items will be further erroded from patient care.

FY89

In FY89, the Northeastern Region will experience a reduction of 718 FTEE because of the following TARGET ALLOWANCE (BUDGET) REDUCTIONS or absorbing costs external to the VA's control:

	$ Millions	FTEE Impact
1% Increased Productivity Reduction	$10.5	312
DHCP Savings	1.3	22
Standardization Savings	0.5	15
Absorb		
Within Grade Costs (Estimate)	6.5	198
January 1989 Health Benefit Rate Increase (Estimate)	5.7	172
TOTAL	$24.5	719

The health care industry is a labor intensive business with the RECURRING BUDGET supporting employment costs (FTEE) of 73% in general medical hospitals and 82% in psychiatric hospitals.

Question 5

s of September 30, 1987, and June 30, 1988, the total number of beds, broken down by the umber of (1) critical care beds, (b) acute medical/surgical beds, (c) acute psychiatric beds, (d) long-term psychiatric beds, and (e) intermediate and nursing home care beds currently not available for patient admissions. Please break down the data according to the following reasons: (1) staffing shortages due to (A) recruitment difficulties, and (B) lack of funds, (2) lack of other operating funds to support available beds, (3) then current construction or renovation projects, (4) decreased demand for beds, and (5) other reasons (please specify).

Answer
As of June 30, 1988, the number of operating beds (broken down by: 1) Critical Care, 2) Acute Medicine/Surgery, 3) Psychiatry, 4) Long Term Psychiatry Intermediate and Nursing Home Care) that were not available for patient admission because of:

A. Staffing Shortages:
  i) due to recruitment difficulties
  ii) due to lack of funds
B. Lack of other operating funds to support available beds,
C. Current construction or renovation projects,
D. Decreased demand for beds,
E. Other specified reasons?

Answer: The following beds were not available for patient admission as of June 30, 1988: (Please note that bed classification does not include Neurology, SCI or Rehab beds)

Bed Classification	Number of Beds
*1. Critical Care	16
2. Acute Medicine/Surgery	1537
**3. Psychiatry	870
4. Intermediate Medicine	347
5. Nursing Home Care	64

The data requested by Service is not available. However, total beds closed because of the requested categories are as follows:

A. Staffing Shortages	
i) Recruitment difficulties	893 Nurses 14 Others 907 Total
ii) Lack of funds - not available	
B. Lack of other operating funds to support available beds.	430
C. Current construction or renovation projects.	917
D. Decreased demand for beds.	687
E. Other specified reasons (space used for other purposes)	275

*Critical Care - Intensive Care and CCU
**Long Term Psychiatry not available as a separate category

Question 6

A. January 29, 1988, and June 30, 1988, the median and average waiting times for non-emergent outpatient appointments in each of the following clinics: general medicine, general surgery, orthopedic, ophthalmology, cardiology, urology, mental hygiene, and substance abuse.

Answer

Reviewing the data concerning waiting times led us to the conclusion that system-wide median and average waiting times would not alone be an accurate indicator of the situation. Some reasons for this are: in arriving at these averages, the same weight would be given to a clinic with only a small number of visits as would be assigned to a clinic having many times as many visits, thus distorting the accuracy of the average. Also such complicating factors as the ability to recruit specialists in certain areas would not be properly reflected. Recruitment of specialists varies dramatically for many reasons and the waiting times naturally vary based on the clinics' ability t staff with appropriate specialists. Thus veterans seeking clinic appointments are subjected to delays in appointment times for a variety of reasons including availability of physicians, nurses and support personnel.

We have concluded that the most representative indicators to provide are the range of waiting time for the requested clinics as well as the mean and median waiting times. Providing the range of waiting times based on regional data should minimize the variations.

Therefore the indicators most reflective of waiting times for veterans in obtaining access to VA outpatient services is expressed as the number of days required for the next available appointment in each clinic as well as the mean and median waiting times considered together.

The following data reflect range of reported waiting times for Region 1 clinics, and the mean and median waiting times:

	Category	Reporting Period	Region Range (days)	Region Average (days)	Region Median (days)
a.	General Medicine	*1/29/88 & 6/30/88	0-80	22	9.5
b.	General Surgery	"	0-48	7	2
c.	Orthopedics	"	0-92	34	38
d.	Opthalmology	"	0-181	40	30
e.	Cardiology	"	0-174	45	30
f.	Urology	"	0-147	32	22
g.	Mental Hygiene	"	0-42	5	1
h.	Substance Abuse	"	0-13	2	0

*Data found to be stable over time, therefore, same data submitted for both reporting periods.

Question 7

As of January 29, 1988, and June 30, 1988, the median and average waiting times for non-emergent inpatient admissions to general medicine, general surgery, orthopedics, urology, acute psychiatry, long-term psychiatry, PTSD in-patient units, substance abuse treatment units, and intermediate and nursing home care beds.

Answer:

Reviewing the data concerning waiting times led us to the conclusion that system-wide median and average waiting times would alone not be an accurate indicator of the situation. Such complicating factors as the ability to recruit personnel in certain areas would not be properly reflected. Recruitment of staff varies dramatically for many reasons and the waiting times naturally vary based on the VAMC's ability to staff with appropriate personnel. Thus veterans seeking admissions are subjected to delays for a variety of reasons including availability of physicians, nurses, support, personnel, geographical location, size of facility, number of like bed sections, proximity to other VAMC's and patients' personal reasons.

We have concluded that the most representative indicators to provide are the range of average waiting times for the requested admissions as well as the mean and median waiting times. Providing the range of average waiting times based on regional data should minimize the variations.

Therefore the indicators most reflective of waiting times for veterans in obtaining access to VA services is expressed as the number of days required for the next available admission appointment in each treatment unit, the mean waiting time and the median waiting time considered together.

The following data reflect Region 1 ranges of reported waiting times for the requested services, as well as the mean and median waiting times:

	Category	Reporting Period	Region Range (days)	Region Average (days)	Region Median (days)
a.	General Medicine	*1/29/88 & 6/30/88	0-30	7	6
b.	General Surgery	"	0-26	8	10
c.	Orthopedics	"	0-41	10	8
d.	Urology	"	0-22	6	8
e.	Alcohol & Drug	"	0-50	6	1
f.	Psychiatry	"	0-30	2	0
g.	Interm. & NHCU	"	0-180	21	7
h.	PTSD	"	0-59	6	0

*Data found to be stable over time, therefore, some data submitted for both reporting periods.

Question 8 : As of January 29, 1988, and June 30, 1988, the median and average waiting times for admission for non-emergent cardiac surgery, orthopedic surgeries requiring prostheses, and intraocular lens implants.

Answer: Reviewing the data concerning waiting times led us to the conclusion that Region-wide median and average waiting times alone would not be an accurate indicator of the situation. Some reasons for this are: in arriving at these averages, the same weight would be given to a VAMC performing only a small number of procedures as would be assigned to a VAMC having many times as many patients, thus distorting the accuracy of the average. Also such complicating factors as the ability to recruit specialists in certain areas would not be properly reflected. Recruitment of specialists varies dramatically for many reasons and the waiting times naturally vary based on the VAMC's ability to staff with appropriate specialists. Thus veterans seeking admissions appointments are subjected to delays in appointment times for a variety of reasons including availability of physicians, nurses and support personnel, geographical location, size of facility, number of like services available in proximity, personal reasons, etc.

We have concluded that the most representative indicators to provide are the range of waiting times for the requested admissions as well as the mean and median waiting times. Providing the range of waiting times based on regional data should minimize the variations.

Therefore, the indicators most reflective of waiting times for veterans in obtaining access to VA service is expressed as the number of days required for the next available admission in each treatment area, the mean waiting time and the median waiting time considered together.

The following data reflect Region 1 ranges of reported waiting times for the requested services as well as the mean and median waiting times:

	Category	Reporting Period	Region Range (days)	Region Average (days)
a.	Cardiac Surgery	*1/29/88 & 1/30/88	0-91	8
b.	Orthopedic Surg. w/Prosthesis	"	0-60	14
c.	Intraocular Lens Implant	"	0-33	6

*Data found to be stable over time, therefore, some data submitted for both reporting periods.

Question 9: For FY 1987 and FY 1988 (as of June 30, 1988), the number of hospitals which have their own cardiac surgery capability that are referring patients to both VA and non-VA sources for such surgery and the number of such referrals and their average cost by VA Region.

Answer:

Cardiac Surgery Referrals

Number referred to VA facility at no cost to referring VAMC:

FY 87	FY 88
50	0

Number referred to VA facility at a cost to the referring VAMC:

FY 87	FY 88
0	0

Number referred to non-VA facility at no cost to referring VAMC:

FY 87	FY 88
16	37

Number referred to non-VA facility at a cost to the referring VAMC:

FY 87	FY 88
13	2

Average Cost:

FY 87	FY 88
$40,000	$36,800

Question 10

For FY 1987 and FY 1988 (as of June 30, 1988), the mean and median vacancy rates for each of the following personnel categories: Psychiatrists, radiologists, anesthesiologists, registered nurses, licensed practical nurses, pharmacists, occupational therapists, physical therapists, and respiratory therapists.

Answer

It has been the experience of DM&S that information on such data elements as vacancy rates, turnover rates, etc., varies significantly from organization to organization. Notably, it has been observed that the data publicized in the private health care sector on vacancy rates for various scarce occupations is derived in a different fashion from the method used by the VA. To the extent that we are informed, vacancy rates published by non-VA health care organizations, typically reflecting private sector data, are generally not comparable to VA rates in that they are calculated based on actual vacancies, as opposed to the net vacancies used by the VA. This appears to be largely attributable to the fact that the private sector is not dealing with the same sort of "authorized ceiling" constraints as are common to the Federal Government. This presents a difficulty in comparing VA vacancy rates to those of other non-governmental organizations since these rates, as used in the VA, show the proportion of net vacancies to authorized FTE staff. The rate is negative when strength exceeds the authorized FTE staff. The formula used in the VA for deriving vacancy rates is as follows:

$$\text{Vacancy Rate} = \frac{\text{Authorized FTE Staff - Actual FTE Staff}}{\text{Authorized FTE Staff}} \times 100$$

It should also be noted that these rates are entirely different indicators from turnover rates which reflect retention at facilities.

Since a vacancy rate for an individual facility is not particularly revealing unless it is viewed in comparison to other facilities, it has not generally been the practice of each VAMC to maintain information on these rates. The actual recruitment activity at an individual medical center is sufficient as an indicator of the severity of a recruitment problem. In view of this, it was not until the initiation of the Survey of Health Occupational Staff in 1986 that the system gathered comparative information on vacancy rates for individual medical centers. The following information has been obtained from the 1986 and 1987 Reports of the Survey of Health Occupational Staff prepared by the Office of Personnel and Labor Relations. (Since vacancy rate information is based on annual data, accurate and comparable FY 1988 data will not be available until the 1988 Survey of Health Occupational Staff is accomplished.)

Registered Nurses

FY86 Vacancy Rate - Northeastern Region = .6%
FY87 Vacancy Rate - Northeastern Region = 7.6%

Highest Facilities (FY87)		Lowest Facilities (FY87)	
1. White River Junction, VT	30.6%	1. Northampton, MA	-10.3%
2. Boston OPC, MA	26.2%	2. Batavia, NY	- 7.4%
3. West Haven, CT	24.9%	3. Canandaigua, NY	- 2.0%
4. Montrose, NY	24.2%	4. Albany, NY	- 0.4%
5. Boston, MA	16.5%	5. Northport, NY	- 0.1%

Licensed Practical/Vocational Nurses

FY86 Vacancy Rate - Northeastern Region = 15.1
FY87 Vacancy Rate - Northeastern Region = 27.5

Highest Facilities (FY87)		Lowest Facilities (FY87)	
1. Montrose, NY	78.2%	1. New York, NY	-17.9%
2. Boston, MA	47.7%	2. Bedford, MA	- 8.0%
3. Manchester, NH	46.3%	3. Syracuse, NY	- 1.3%
4. Northampton, MA	44.0%	4. Batavia, NY	4.7%
5. Providence, RI	40.0%	5. White River Jct., VT	8.6%

Pharmacists

FY86 Vacancy Rate - Northeastern Region = 7.8%
FY87 Vacancy Rate - Northeastern Region = 3.2%

Highest Facilities (FY87)		Lowest Facilities (FY87)	
1. Bath, NY	28.6%	1. Newington, CT	-10.0%
2. Bronx, NY	24.8%	2. Boston, MA	- 9.8%
3. Manchester, NH	21.4%	3. Brooklyn, NY	- 9.3%
4. Buffalo, NY	20.3%	4. Bedford, MA	- 7.7%
5. Northampton, MA	14.3%	5. San Juan, PR	- 7.7%

Occupational Therapists

FY86 Vacancy Rate - Northeastern Region = 24.6%
FY87 Vacancy Rate - Northeastern Region = 16.3%

Highest Facilities (FY87)		Lowest Facilities (FY87)	
1. Bath, NY	100%	1. Castle Point, NY	-66.7%
2. Bronx, NY	70%	2. Canandaigua, NY	-50.0%
3. Providence, RI	60%	3. San Juan, PR	-12.0%
4. Northport, NY	50.4%	4. New York, NY	- 7.0%
5. Montrose, NY	45.5%	5. Albany, NY	0.0%

Physical Therapists

FY86 Vacancy Rate - Northeastern Region = 25.6%
FY87 Vacancy Rate - Northeastern Region = 22.6%

Highest Facilities (FY87)		Lowest Facilities (FY87)	
1. Montrose, NY	57.1%	1. Castle Point, NY	-25.0%
2. Newington, CT	55.7%	2. White River Jct.,VT	-25.0%
3. West Haven, CT	54.0%	3. San Juan, PR	- 8.3%
4. Bath, NY	50.0%	4. Batavia, NY	0.0%
5. Brooklyn, NY	40.0%	5. Canandaigua, NY	0.0%

Certified/Registered Respiratory Therapists

FY86 Vacancy Rate - Northeastern Region = 16.8
FY87 Vacancy Rate - Northeastern Region = 24.4

Highest Facilities (FY87)

1.	Montrose, NY	100%
2.	Bronx, NY	84.6%
3.	Bath, NY	80.0%
4.	Brooklyn, NY	68.4%
5.	Manchester, NH	46.2%

Lowest Facilities (FY87)

1.	Togus, ME	-100%
2.	West Haven, CT	-85.7%
3.	San Juan, PR	-33.3%
4.	White River Jct.,VT	0.0%
5.	Batavia, NY	0.0%

Answer: Physician data not available in Survey of Health Occupational Staff prepared by the Office of Personnel and Labor Relations. Therefore, facility input utilized for these categories and calculated as follows:

$$\text{VACANCY RATES} = \frac{\text{Vacancies}}{\text{Authorized}} \times 100$$

Part-Time = 1/2

	Psychiatrists			Radiologists			Anesthesiogists		
	Auth.FTEE	Vacancies	Vac. Rates	Auth.FTEE	Vacancies	Vac. Rates	Auth.FTEE	Vacancies	Vac. Rates
REGION 1 TOTAL	334.2	63.8	19.1	115.4	19.2	16.6	61.2	7	11.4

Question 11

An estimate of the dollar reductions in inventories for drugs, medical supplies, and prosthetics during FY 1988 (as of June 30, 1988), and the number of times facilities in your region have been depleted of critical items or medications or have experienced critical shortages of these items or medications during FY 1988.

Answer: It is estimated that there was a reduction of $6,099,365 in inventories for drugs, medical supplies and prosthetics during FY 1988-to-date. There were no known life-threatening instances where critical shortages of critical items or medications occurred.

Question: 12. The current level of funds available to support contract community nursing home care payments for the balance of FY 1988 and the projected amount that will be available in FY 1989.

Answer:
12. The funds unobligated at the end of July were $7,323,000 out of a total allotment for the year of $44,710,000. The FY 1988 costs of $37,378,000 are 83.6% of the total allotment. This compares with the 305 out of 366 days in this fiscal year at 83.3%.

Funding provided for FY 1989 is $45,922,000, an increase of only 2.7% over FY 1989.

Question 13

For FY 1988 (as of June 30, 1988), the rate of surgical postponements and of cancellations due to staff shortages and an estimate of the average delay involved for postponements and what proportion of the postponements involved more than one postponement for a particular veteran.

Answer

FY88 (As of June 30, 1988)

	Total Surgeries	Total Postpon.	Postponement Rate	Av.Length of Delay(days)	#Multiple Postponements	Proportion of Multiple Postponements
Region 1 TOTAL	30,120	1742	5.8%	4.7 days	253	14.5%

Regional Director
Northeastern Region

P.O. Box 8500
Albany, N.Y. 12208

Veterans
Administration

September 21, 1988

Honorable Alan Cranston
Chairman, Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Senator Cranston:

Enclosed please find my response to the follow-up questions contained in your letter of September 12, 1988.

I appreciate the opportunity to respond to these questions in light of our mutual concern with preserving a quality health care system for our nation's veterans.

Sincerely,

Al Washko

AL WASHKO
Regional Director
Northeast Region

Enclosure

In Reply Refer To:
(10BA1)

QUALITY: Our Highest Priority
Manage It—Reward It

Regional Director
Northeastern Region

P.O. Box 8500
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Veterans
Administration

FOLLOW-UP QUESTIONS

QUESTION #1:

On page 1 of the Chief Medical Director's Task Force report, it is recommended that the RAM as a resource-redistribution tool be discontinued. What is the rationale behind this recommendation?

RESPONSE:

The Bell Report stated:

> "A major recommendation made in association with workload reductions represents the initial step in moving the system toward access parity by adjusting workloads and funding in accordance with entitlement and eligibility. In addition, the Task Force recommends suspension of the Resource Allocation Model a a resource-distribution tool for FY 1990 and FY 1991."

Two important points need emphasis. First, the recommendation was to suspend, not eliminate the RAM. Second, the report recommended suspending the RAM as a resource-distribution tool, but left open the use of the RAM as a productivity monitor.

It is apparent that the FY 1989 budget was not sufficient to continue services at their present level. This will likely lead to workload reductions in discretionary categories.

Continuing the RAM in this environment would pose two problems. First, the RAM does not differentiate among eligibility categories when funding workload. Second, the RAM has incentives to increase workload rather than reduce workload. These factors would conflict with workload controls which became necessary because of budget limitations.

By suspending the RAM for allocation purposes, the conflict would be less severe. In addition, time would be provided to modify the RAM and bring it in harmony with the discretionary workload controls.

In Reply Refer To:
(10BA1)

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QUESTION #2:

The Task Force listed a total of 86 options which might be considered to offset the anticipated 1989 shortfall. Are you aware of any facilities in your region which have implemented, in whole or in part, some of these options or have attempted to implement them this fiscal year or are anticipating implementing these options in 1989? Please provide details.

RESPONSE:

It has become increasingly apparent over the past several years, that the erosion of the Department of Medicine and Surgery's budget in relative terms, has seriously impacted our ability to provide quality care to our veteran patients.

Although VA Medical Centers throughout the Northeast Region have enacted a number of "belt tightening" initiatives and have greatly improved operational efficiency over the past several years, it is evident that in order to provide quality care at all facilities we must either obtain additional resources or, if this is not feasible, reduce services. It is widely anticipated in Region 1 that this dilemma should be addressed in the absence of major budget increases by program consolidations and/or eliminations (Option 22), mission changes and possibly hospital closures. With the increased emphasis on programs which serve as alternatives to acute care and the increasing need for long term care services, it stands to reason that particularly in metropolitan areas some VAMC's could undergo mission changes.

A number of the options listed by the CMD Task Force have been been implemented in whole or part this fiscal year in a majority of our facilities.

These include:
    Option 19 - Delay in filling vacant positions
    Option 42 - Consolidate patients on fewer wards
    Option 11 - Balance accounts - reduce equipment and maintenance
    Option 16 - Standardize procurements for economies/efficiencies

In Reply Refer To:
(10BA1)

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Options which are under consideration for implementation at a majority of our VA Medical Centers in FY 1989 include:

- Option 49 - Adjust FTEE floor - Because we are a labor intensive industry, the most feasible way of addressing budget reductions is adjusting FTEE. Congressional assignment of an FTEE floor greatly restricts management's ability to make budget adjustments. Most Medical Centers reported that adjusting the FTEE level was the most feasible option to implement. Without substantial additional resources, our FTEE must be adjusted downward significantly.
- Option 44 - Increase procurement standardization at District level
- Option 42 - Consolidate patients on fewer wards
- Option 16 - Standardize procurements for Economies/Efficiencies
- Option 3 - Eliminate funding for beneficiary travel
- Option 18 - Elimination of new satellite OPC's
- Option 66 - Assigned bed levels - more realistic Congressional bed levels

In addition, I feel that should it become necessary to systematically restrict discretionary workload (Category B and C Veterans), then the issue of equitable access to care throughout the country becomes much more important. Relative to this issue, the general concept of a single (Means Test) income threshold for all areas of the country needs to be studied to ensure equitable access for all veterans. Utilizing the same income threshold in Mississippi and Alaska erroneously assumes that the cost of living in these areas is comparable. Rather, it would make more sense to set means test income thresholds by state or preferably by county. It is suggested that any such study include an analysis of the impact of implementation on operations.

QUESTION #3

Please describe those options from the Report that you believe are most feasible to implement in your region and those that would be most disruptive and harmful. You may restrict yourself to the top 18 options, if you wish.

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RESPONSE:

A majority of the responses from the field indicate that the following Options would be the most feasible to implement in Region 1:

Option 49 - Adjust FTEE floor (see discussion under Question 2)
Option 44 - Increase procurement standardization at the District level
Option 46 - Limit beneficiary travel to only interstation transfers
Option 21 - Rigorous review of VAMC missions
Option 3 - Eliminate funding for beneficiary travel
Option 16 - Standardize procurements for economies/efficiencies
Option 80 - Discontinue management efficiency reviews (MEO's)

In addition, as discussed under Question 2, I would strongly suggest that Option 22 (Medical Center Program and Management Consolidation) is feasible with appropriate planning and phase-in.

The options which a majority of facilities in Region 1 feel would be the most disruptive and harmful include the following:

Option 14 - Reduce support to medical residency program
Option 20 - Employee furloughs as last resort
Option 52 - Drop prescription drugs for all outpatient care
Option 53 - Defer all FY 1989 construction obligations for one year
Option 11 - Balancing accounts - Reduce equipment and maintenance
I personally feel that continued implementation of Option 11 is a blueprint for obsolescence and will render our facilities into an unacceptable situation from which we could not recover.

Veterans Administration

Responses for the Senate Committee on Veterans' Affairs

A. Zamberlan
Regional Director
Great Lakes Region
September 9, 1988

Response to SVAC Questionnaire

1. The projected (a) costs for the remainder of FY 1988 and for FY 1989 resulting from the enactment of Public Law 100-322 for (1) the increases in total reimbursements and administrative costs for the beneficiary travel program (and the annual totals for each), (2) registered nurse Saturday premium pay, (3) State home per diem increases, and (4) outpatient care for those for whom care was mandated in the new law, and (b) funding specifically provided to your region for these costs in FY 1988 and projected to be provided for FY 1989.

Response:

Public Law 100-322 set out a number of provisions that will put additional strains on the FY 1988 and 1989 budgets. Some funding has been put out this year to address these expanded responsibilities; however, projections indicate that significant shortfalls will exist in FY 1989, particularly if the beneficiary travel program continues next fiscal year. The following table describes the projected costs and funding supplements for beneficiary travel, RN Saturday premium pay, State home per diem, and outpatient care expanded eligibility. It is apparent that beneficiary travel is the major component of the shortfall, with premium pay being another significant factor.

	FY 88		FY 89	
	Projected Costs	Funding	Projected Costs	Funding
Beneficiary Travel				
P.L. 100-322 provisions	$ 486,138		$2,242,226	0
Total reimbursements	$7,731,600	$1,221,694	$9,552,487	0
Beneficiary Travel - Administrative Costs				
P.L. 100-322 provisions	$ 176,862		$ 707,448	0
Total program	$1,043,147	0	$1,288,825	0
RN Saturday Premium Pay	$1,044,598	$ 821,924	$2,834,328	0
State Home per diem	$ 846,548	$1,781,368	$2,579,723	0
Expanded Outpatient Care (P.L. 100-322)	$ 309,835	$ 568,841	$2,280,485	0

2. The current FY 1988 (as of June 30, 1988) and projected remainder of FY 1988 and all of FY 1989 (a) costs for the payment of (1) special salary rates, (2) unfunded expenses for special drugs and other care for AIDS patients and for AIDS research, and (3) educational and training expenses resulting from the enactment of Public Law 100-322, related to the care and treatment of AIDS patients, and (b) funding specifically provided to your region for these costs in FY 1988 and projected to be provided for FY 1989.

Response:

Special Salary Rates:

Special salary rates have proven to be an effective means of easing staffing shortages in areas where personnel in certain medical occupations may be scarce. The funds required to support these special rates, however, exceeds what was originally anticipated and funded.

Since the VA accounting system does not identify actual costs associated with special salary rates, costs represented below are based on approved funding levels. Projected costs for FY 89 represent both the rates approved in FY 88 and an estimated 5.7 million required to support new special salary rates.

Special Salary Rates
Cost/Funding

	Estimated Cost	Region Funding	VACO Funding	Facility Absorption
FY 88				
thru 6/30/88	$2,884,154	$295,076	$2,245,159	$ 343,919
thru 9/30/88	$5,399,299	$409,897	$4,538,025	$ 451,377
FY 89 based on FY 88 approvals	$8,452,355	$456,923	$7,518,996	$ 276,436
FY 89 projected requirements	$5,700,000	0	$5,700,000	0

Q 2.

AIDS:

None of the facilities in Region 4 were included as one of the 25 hospitals with the highest number of AIDS cases, so no supplemental funding was received to treat AIDS patients. The costs and projections listed below are associated primarily with the FY 88 AIDS caseloads experienced by our Chicago area hospitals.

	thru 9/30/88	Funding	FY 89 Projection	Funding
Unfunded expenses				
Treating for AIDS patients	$6,000,000	0	$7,900,000	0
AZT	$ 500,000		$ 600,000	
Pent.	$ 2,373		$ 37,147	
Education & Training				
Expenses in P.L. 100-322	$ 393,636	$ 92,802	$1,000,000	0
Voluntary testing			$ 600,000	

3. For FY 1988 (as of June 30, 1988), for the remainder of FY 1988, and for FY 1989 the (a) costs of implementing universal precautions as recommended by the Centers for Disease Control in Atlanta, Georgia, and required by the Occupational Safety and Health Administration for the purpose of protecting VA health-care workers against infectious diseases, and (b) funding specifically provided to your region for these costs in FY 1988 and projected to be provided for FY 1989.

Response:

The costs of implementing universal precautions against infectious diseases is very difficult to project. The activities, education and supplies associated with the precautions are becoming part of the standard operating procedures at all facilities, and are not tracked as separate expenditures. We have attempted to present the most accurate costs possible. The following figures reflect our best estimate of these costs:

	FY 88 Costs			FY 89	
	6/30/88	9/30/88	Funding	Costs	Funding
Universal Precautions	$1,476,130	$3,400,000	0	$3,700,000	0

4. The total amount of funds shifted in FY 1988 (as of June 30, 1988), projected to be shifted for the rest of FY 1988, and projected to be shifted in FY 1989 from all non-recurring accounts, listed separately, to cover current and anticipated operational needs (please describe them).

Response:

The funds we have shifted to cover FY 1988 operational needs are presented on the attached spread sheet. As can be seen, the diversions for the first three quarters of FY 1988 totalled approximately $9,710,985 and the diversions for the final quarter of FY 1988 are predicted to be $3,236,995, for a total of $12,947,980.

In order to maximize our managerial flexibility, we have waited to formally convert the funds until late this fiscal year. In practical terms, however, the funds were committed to diversions early in the year. To present an accurate picture of our accounting activities we have therefore taken three-quarters of our predicted end of year diversions, rather than the actual dollar amount which was officially reported diverted as of June 30, 1988. Reporting actual conversions to all other funds as of June 30, 1988, would under represent our true diversion activities.

It is also noteworthy that Region 4 has dropped a significant number of FTEE since the end of the first quarter and reduced our diversions from the levels originally expected. Unanticipated supplemental funds from the Congress have also reduced the amount of diversions planned for the fourth quarter. Since January 1, 1988, we have dropped 403 FTEE on a non-cumulative basis. The downward trend has been steady and continuing, so that we now project finishing the fiscal year at our assigned FTEE of 28,436.2. The impact of maintaining this FTEE level is apparent -- we are no longer able to support our equipment and NRM programs, reduced our activations to only the most essential, reduced our operating inventories, and have encouraged our managers to be innovative in reducing non-salary operating costs in the face of an escalating medical CPI.

	Diversions Through 6/30/88	Planned 4th Quarter Diversions
NRM (.23)	$6,095,977	$2,031,992
Replacement Equipment (.19)	1,806,442	602,147
Additional Equipment (.20)	1,046,302	348,767
ADP (.900)	258,758	86,253
*.020	121,976	40,659
*Contract Hospital (.21)	132.078	44,026
*CNHC (.24)	249,452	83,151
TOTAL	$9,710,985	$3,236,995

*These diversions are taking place at the management flexibility pilot site in Region 4.

5. As of September 30, 1987, and June 30, 1988, the total number of beds, broken down by the number of (a) critical care beds, (b) acute medical/surgical beds, (c) acute psychiatric beds, (d) long-term psychiatric beds, and (e) intermediate and nursing home care beds currently not available for patient admissions. Please break down the data according to the following reasons: (1) staffing shortages due to (A) recruitment difficulties, and (B) lack of funds, (2) lack of other operating funds to support available beds, (3) then current construction or renovation projects, (4) decreased demand for beds, and (5) other reasons (please specify).

Response:

The following beds were not available for patient admission as of June 30, 1988:

Bed Classification	Beds Not Available
Critical Care	26
*Acute Med/Surg	919
Psychiatry (acute & long term)	863
Intermediate	250
Nursing Home	0
TOTAL	2,058

*Includes medicine, surgery, neurology, rehabilitation, SCI and blind rehab.

We are unable to break down the reasons for bed closures by service; however, total beds closed in the region are due to the following:

Reason	Number of Beds Closed
Nursing/Recruiting	38
Demand	815
Construction	723
Lack of Funds	399
Other Staff Recruiting	10
Space/Other	73
Total	2,058

Data from September 30, 1987 is not readily available. It can be supplied for the record if the Committee requests.

6. As of January 29, 1988, and June 30, 1988, the median and average waiting times for non-emergent outpatient appointments in each of the following clinics: general medicine, general surgery, orthopedic, ophthalmology, cardiology, urology, mental hygiene, and substance abuse.

Response:

The following data reflect the range of average waiting times for our facilities, broken out by different clinics. The range, we feel, gives a perspective of the differences we face in Region 4. Waiting time is affected by a number of items, including the ability to recruit specialists, nurses and support staff, and the ability to adequately fund activities.

In general, the ranges have remained the same from January to June, with the exception that General Surgery and Orthopedics now have a much smaller range.

Category	Reporting Date	Range of Average Waiting time (days)
General Medicine	1/29/88	0- 92
	6/30/88	0-109
General Surgery	1/29/88	0-109
	6/30/88	1- 64
Orthopedics	1/29/88	1-170
	6/30/88	0- 90
Ophthalmology	1/29/88	0-149
	6/30/88	0-158
Cardiology	1/29/88	0-130
	6/30/88	1-131
Urology	1/29/88	0-122
	6/30/88	0-131
Mental Hygiene	1/29/88	0- 27
	6/30/88	0- 43
Substance Abuse	1/29/88	0- 23
	6/30/88	0- 27

Q 6.

Also presented are the median and average waiting time for the clinics. We would caution that the median would be adversely affected by a single facility which may happen to be a statistical outlyer. Likewise, the mean may present a distorted picture of the true average waiting time since a small facility with only a few patients counts the same as a larger facility serving many more veterans. Weighting the different facilities by the number of veterans would help to address this problem.

Median and Average Waiting Time for Outpatient

Category	Reporting Date	Median	Average Waiting Time (Mean)
General Medicine	1/29/88	86	23.6
	6/30/88	54.5	29.1
General Surgery	1/29/88	54.5	15.8
	6/30/88	32	17.8
Orthopedics	1/29/88	85	48.6
	6/30/88	45	41.4
Ophthalmology	1/29/88	74.5	40.3
	6/30/88	79	46.8
Cardiology	1/29/88	65	42.2
	6/30/88	65.5	46.6
Urology	1/29/88	61	39.1
	6/30/88	65.5	36.9
Mental Hygiene	1/29/88	13.5	7.3
	6/30/88	21.5	8.8
Substance Abuse	1/29/88	11.5	3.5
	6/30/88	13.5	4.5

7. As of January 29, 1988, and June 30, 1988, the median and average waiting times for non-emergent inpatient admissions to general medicine, general surgery, orthopedics, urology, acute psychiatry, long-term psychiatry, PTSD inpatient units, substance abuse treatment units, and intermediate and nursing home care beds.

Response:

The following data reflect the range of average waiting times for our facilities, broken out by different clinics. The range, we feel, gives a perspective of the differences we face in Region 4. Waiting time is affected by a number of items, including the ability to recruit specialists, nurses and support staff, and the ability to adequately fund activities.

Category	Reporting Date	Range of Average Waiting time (days)
General Medicine	1/29/88	0- 3
	6/30/88	0- 26
General Surgery	1/29/88	0- 21
	6/30/88	0- 29
Orthopedics	1/29/88	0- 42
	6/30/88	0- 87
Urology	1/29/88	0- 21
	6/30/88	0- 32
Alcohol & Drug	1/29/88	0- 65
	6/30/88	0- 66
Acute/Long	1/29/88	0- 5
Term Psych	6/30/88	0- 22
Intermediate/	1/29/88	0- 21
Nursing Home Care	6/30/88	0- 22
PTSD	1/29/88	0- 51
	6/30/88	0- 42

Q 7.

Also presented are the median and average waiting time for the clinics. We would caution that the median would be adversely affected by a single facility which may happen to be a statistical outlyer. Likewise, the mean may present a distorted picture of the true average waiting time since a small facility with only a few patients counts the same as a larger facility serving many more veterans. Weighting the different facilities by the number of veterans would help to address this problem.

Following are the median and average waiting time for non-emergent inpatient admissions.

Category	Reporting Date	Median	Average Waiting Time (Mean)
General Medicine	1/29/88	1.5	0.6
	6/30/88	13	2.1
General Surgery	1/29/88	10.5	2.1
	6/30/88	14.5	4.2
Orthopedics	1/29/88	21	3.7
	6/30/88	43.5	13.7
Urology	1/29/88	10.5	2.6
	6/30/88	16	4.9
Alcohol & Drug	1/29/88	32.5	7.5
	6/30/88	33	10.3
Acute/Long Term Psych	1/29/88	2.5	0.8
	6/30/88	11	2.1
Intermediate/ Nursing Home Care	1/29/88	10.5	4.6
	6/30/88	11	5.3
PTSD	1/29/88	25.5	22.3
	6/30/88	21	16.7

8. As of January 29, 1988, and June 30, 1988, the median and average waiting times for admission for non-emergent cardiac surgery, orthopedic surgeries requiring prostheses, and intraocular lens implants.

Response:

The following data reflect the range of average waiting times for our facilities, broken out by different clinics. The range, we feel, gives a perspective of the differences we face in Region 4. Waiting time is affected by a number of items, including the ability to recruit specialists, nurses and support staff, and the ability to adequately fund activities.

Cardiac surgery has witnessed a major increase in the range of waiting time over the period from January to June.

Category	Reporting Date	Range of Average Waiting time (days)
Cardiac Surgery	1/29/88	0- 28
	6/30/88	0- 52
Surgery Requiring Prosthetic Device	1/29/88	0-195
	6/30/88	0-196

Also presented are the median and average waiting time for the clinics. We would caution that the median would be adversely affected by a single facility which may happen to be a statistical outlyer. Likewise, the mean may present a distorted picture of the true average waiting time since a small facility with only a few patients counts the same as a larger facility serving many more veterans. Weighting the different facilities by the number of veterans would help to address this problem.

Following are the median and average waiting time for non-emergent cardiac and prosthetic surgery.

Category	Reporting Date	Median	Average Waiting Time (Mean)
Cardiac Surgery	1/29/88	14	18.2
	6/30/88	26	24.0
Surgery Requiring Prosthetic Device	1/29/88	97.5	26.6
	6/30/88	98	28.4

9. For FY 1987 and FY 1988 (as of June 30, 1988), the number of hospitals which have their own cardiac surgery capability that are referring patients to both VA and non-VA sources for such surgery and the number of such referrals and their average cost by VA region.

Response:

As can be seen by the following data, very few referrals now occur at facilities with cardiac surgery capabilities. Forty-three of the referrals in FY 87 were a result of a temporary closure of the cardiac surgery section at Cleveland. All cases were referred to non-VA hospitals due to the large distance to the nearest VA hospital.

	FY 87	FY 88
a. Number of hospitals with cardiac surgery capability that refer patients	3	1*
b. Number of patients referred to other VA hospitals (from A)	3	0
c. Number of patients referred to non-VA hospitals	46	1
d. Average cost of referrals to non-VA hospitals	$21,770	$ 0

*The single referral for FY 88 had no cost since it involved a private payment patient.

10. For FY 1987 and FY 1988 (as of June 30, 1988), the mean and median vacancy rates for each of the following personnel categories: Psychiatrists, radiologists, anesthesiologists, registered nurses, licensed practical nurses, pharmacists, occupational therapists, physical therapists, and respiratory therapists.

Response:

It is very difficult to calculate vacancy rates on a regional basis. Because of differences in how rates are derived, the rates in the VA versus the private sector are not comparable. We are presenting information received in a survey of our field facilities. It was clear from the data received reflected difference in interpretation of the question and variances in how rates were calculated. Therefore, we present this data with many reservations about its integrity and recommend it not be used for comparison purposes.

Vacancy Rates by Occupational Category

	FY 87		FY 88	
	Mean	Median	Mean	Median
Physicians				
Psychiatrists	14%	50%	17%	50%
Radiologists	16%	50%	17%	50%
Anesthesiologists	19%	50%	18%	50%
Nurses				
RN's	13%	16.5%	11%	13.5%
LPN's	18%	24.5%	18%	19.5%
Pharmacists	16%	25%	15%	19.5%
Therapists				
Occupational	28%	50%	25%	50%
Physical	41%	50%	35%	50%
Respiratory	12%	50%	10%	10%

11. An estimate of the dollar reductions in inventories for drugs, medical supplies, and prosthetics during FY 1988 (as of June 30, 1988), and the number of times facilities in your region have been depleted of critical items or medications or have experienced critical shortages of these items or medications during FY 1988.

Response:

Region 4 facilities estimated that inventories for drugs, medical supplies and prosthetics will be reduced by $8,448,220 during FY 88. Although shortages have occurred, management has ensured that none have been so critical as to effect the quality of care given to patients. The region would be apprised of any life-threatening or critical shortages so that these situations could be resolved in a coordinated and timely manner.

12. The current level of funds available to support contract community nursing home care payments for the balance of FY 1988 and the projected amount that will be available in FY 1989.

Response:

Region 4 strongly supports the community nursing home program and has led the VA in CNHC fund usage over the last several years. Contract nursing homes allow the VA to place patients in the most appropriate treatment modality, thereby freeing up resources for needed programs and patients. Demographic projections show an increasingly elderly veteran population. Given these statistics and the resulting demand for nursing home care, contract community nursing homes will become even more important. Following are data on the balance of funds available as of July 30, 1988 and funds made available for FY 89 in the target allowance:

7/30/88	FY 88 Total	FY 89 Total
$14,060,273	$56,241,092	$57,700,309

13. For FY 1988 (as of June 30, 1988), the rate of surgical postponements and of cancellations due to staff shortages and an estimate of the average delay involved for postponements and what proportion of the postponements involved more than one postponement for a particular veteran.

Response:

Surgical postponements and cancellations due to staff shortages have not been a major issue in Region 4. With 666 postponements out of almost 30,000 surgeries (excluding ambulatory procedures), the rate of postponement is about 2.2 percent. When a procedure is cancelled, the delay before the surgery can be rescheduled averages 8.2 days. Forty veterans out of the 666 delays identified (6.01 percent) have been postponed on multiple occasions, elective surgeries.

Great Lakes Region
P.O. Box 1407
Ann Arbor MI 48106

Veterans
Administration

September 20, 1988

In Reply Refer To 10BA4

Honorable Alan Cranston
Chairman, Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510-6375

Dear Mr. Chairman:

Enclosed are responses to your questions regarding the Chief Medical Director's Task Force on the FY 89 budget. As discussed with your staff, my travel schedule did not permit me to respond by September 19, and I appreciate the extension of the response deadline.

Thank you for the opportunity to provide this information to you and your committee.

Sincerely,

A. ZAMBERLAN
Regional Director
Great Lakes Region

Enclosure

Senate Veterans Affairs Follow-up Questions
Submitted by Senator Alan Cranston

1. On Page 1 of the Chief Medical Director's Task Force Report, it is recommended that the RAM as a resource-redistribution tool be discontinued. What is the rationale behind this recommendation?

Response:

As we attempt to address our budget shortfalls, we will have to scale back the discretionary services which have been routinely provided in the past. Although we believe the RAM equitably distributes resources based upon facility complexity and efficiency, it provides incentives to increase workload within available resources. Therefore, the RAM must be suspended as an allocation tool on a temporary basis so that we do not penalize individual facilities for making the cuts in discretionary workload that must be made to ensure the system's financial integrity.

The issue is not the RAM -- it has proven to be a valuable management tool since its implementation in FY 85. Given current resources, however, we cannot continue to maintain a system that rewards increasing the quantity of services provided as we are trying to limit workload.

2. The Task Force listed a total of 86 options which might be considered to offset the anticipated 1989 shortfall. Are you aware of any facilities in your region which have implemented, in whole or in part, some of these options or have attempted to implement them this fiscal year or are anticipating implementing these options in fiscal year 1989? Please provide details.

Response:

Within Region 4, medical center directors have incorporated cost-containment activities as one of their overriding management goals. For example, all new initiatives which we fund are reviewed in light of anticipated net savings. Several of the mentioned options in the Bell Report are regularly enacted by Region 4's facilities, including:

--delaying filling vacant positions,
--deferring equipment purchases and maintenance and repair projects,
--consolidating patients on fewer wards, and
--limiting community nursing home placement (for non-service connected veterans).

Additionally, our region has established a cost-containment task force charged with exploring various cost-saving measures which we may immediately implement. Several very worthwhile proposals have already emerged from their work.

It is apparent that given the fiscal austerity, the regions will be working closely with the Chief Medical Director over the next few months to refine the list of possible options which can lead to cost savings, including workload reductions.

3. Please describe those options from the report that you believe are most feasible to implement in your region and those that would be most disruptive and harmful. You may restrict yourself to the top 18 options, if you wish.

Response:

All of the top 18 options could be implemented; we would caution that some of the options would require a phasing in over several years to avoid disrupting the system. Phased in changes will not realize cost savings immediately. In particular, reductions in workload will require employment reductions in FY 89 which cannot be accomplished without RIF authority.

Some of the proposals affect the VA infrastructure and decrease our capability to continue to deliver high quality care to our veteran population. Deferring equipment purchases, maintenance and repair expenditures, and minor construction projects, are stop gap measures with major impacts in the future.

We would also argue that a regional adjustment to the means test needs to be enacted. Other federal programs have recognized the need to account for geographic differences in cost of living. There adjustments, based upon the varying costs of living in the different regions, would help provide equitable access to health care. As I mentioned in my testimony, the current system that sets one income level as a national standard, irrespective of geographic location, unfairly penalizes those veterans who must pay more for the basic necessities of living. To avoid this, our preliminary research suggests that a 17 percent adjustment to the current means test should occur in the Great Lakes Region, 24 percent in the Northeast Region, and 20 percent in the Western Region.

I feel that the following options could be implemented in FY 89:

--eliminate beneficiary travel,
--defer high/tech - joint sharing procurements,
--eliminate chronic outpatient and fee for service dialysis by transferring appropriate patients to HCFA,
--decentralize non-VA workloads,
--eliminate over the counter drugs or require copayment,
--eliminate MEDIPP funding in FY 89,
--reduce transplant workloads, and
--phase in of workload employment and programmatic reductions.

Another option which would increase management flexibility and enhance our ability to meet the challenges of the FY 89 budget would require Congressional action to remove the current mandate on AIDS funding and eliminate the existing employment floors and ceilings.

The most disruptive options from our perspective would be:

--applying workload reductions without incorporating adjusted means tests reflecting varying costs of living, and
--applying programmatic and FTEE reductions without plans for a multi-year phase in.

OCT 6 1988

Honorable Alan Cranston
Chairman, Committee on
Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Enclosed please find the Agency's responses to questions raised by you following the September 9, 1988, hearing on the Veterans Administration Health Care. Thank you for the opportunity to provide this additional information for the record.

Sincerely,

(Signed) Thomas K. Turnage

THOMAS K. TURNAGE
Administrator

Enclosure

DISPATCHED
OCT 6 1988
ADMINISTRATOR'S OFFICE

FLCONWAY:sja 9/23/88 #8809092

SENATOR CRANSTON

Question: 1. NOVA's testimony states on page 3 that the Washington, D.C., VAMC has an advertising budget of $15,000 per quarter to attract applicants and that NIH has a budget of $350,000 to recruit in the same market. Are you aware of this discrepancy and does DM&S have plans to increase the advertising budget for this facility and others which may find themselves in a similar non-competitive situation?

Answer: DM&S has acknowledged that there is a need to significantly expand the advertising effort and to improve the image of the VA as a health care employer. This was a specific recommendation of the Recruitment and Retention Task Force that has been approved by the Chief Medical Director. The Department is actively working with the Office of Personnel and Labor Relations to implement the recommendation. As a part of this, it is expected that the Department will fund the design and effectuation of a major image campaign. Additionally, the Task Force recommended that, to the extent that funds can be made available, Medical Center Directors should be encouraged to significantly expand their recruitment/advertising budgets. Further, DM&S has committed $40,000 to the National Commission on Nursing Implementation Project involving an Ad Council Campaign about the nursing profession. This support will be recognized throughout the campaign and in upcoming nursing literature.

However, it is important to note that the comparison of the VAMC Washington, D.C. and the National Institutes of Health with respect to the size of their recruitment budgets is an inappropriate comparison. The NIH is definitionally a national institution and is funded accordingly. The VAMC Washington, D.C. is but one of 172 VA health care facilities. While a $15,000 advertising budget may be inadequate for that facility, it should not be expected to be comparable to that of a national level organization. Further, it is important to note that facilities are not "given" advertising budgets. Rather, these are funds that each VAMC Director is able to identify from within his unearmarked Medical Care budget for the Medical Center. Given other patient care demands, it may be that a facility is unable to adequately fund a recruitment advertising effort.

Lastly, DM&S identified and spent $100,000 for the purposes of national recruitment efforts in FY 1988. It is expected that the FY 1989 budget for this purpose will be significantly larger. These funds are used for the placement of advertisements in national journals and other such publications, for exhibits, and for other recruitment tools such as the "give-aways" used at conventions. Additionally, considerable funds are expended for the travel of recruitment specialists and occupational representatives to attend professional meetings, conventions, and job fairs.

SENATOR CRANSTON

Question: 2. NOVA states on page 5 of its testimony that when it asked VA nurses if "there were difficulties in securing adequate supplies for patient care", an astounding 82 percent answered yes. Please comment on that statement.

Answer: In developing testimony for the September 9, 1988, SVAC Hearing on Veterans' Administration Health Care Oversight, NOVA sent a questionnaire to Chief Nurses at all VA facilities and to all NOVA chapter presidents (total questionnaires sent approximately 225). The questionnaire requested information regarding the budgetary impact upon the recruitment and retention of nursing personnel and upon the allocation of supplies and equipment to meet the needs of patients. Fifty, or 22% of those queried responded to the questionnaire. Eighty-two percent of the 50 responding (41 facilities) indicated many difficulties were encountered in securing supplies/equipment for patients. Specific facilities were not identifiable in the survey results. When supplies/equipment items are needed to provide care to patients, every effort is made by local facility personnel to secure these items.

Question: 3. On Page 4 of Dr. Des Prez's testimony, he states that "the whole area of medical and surgical cardiology in the VA is in crisis". Do you agree with that statement and, if not, why not?

Answer: I cannot agree with this global assessment of the status of cardiology in the VA health care system. The Veterans Administration has for many years recognized the importance of cardiology as a vital component of medical care at VA medical centers. Specific guidelines have been created by VA Central Office staff to encourage medical centers staff to pay special attention to the need for cardiology services. VACO has supported the creation of 70 cardiac catheterization laboratories and 30 electrophysiology laboratories. Non-invasive cardiology laboratories systems have been established at all DM&S hospitals and in many psychiatric and long term care hospitals as well. The VA has pioneered computerization of electrocardiography (AECGIS System) and has the only complete and probably the largest Pacemaker Surveillance System and Registry in the USA if not the whole world. We monitor mortality and morbidity closely and have the lowest adverse experience record in the USA.

The VA cardiologists participate extensively in research and teaching. About 25% of all American Cardiologists receive their training through the VA system. VA cardiologists have captured multimillion dollar research awards and are leaders in many areas. The VA purposefully has set its workload requirements at somewhat lower levels than in the private sector to encourage research and teaching.

SENATOR CRANSTON

It is true that salaries for personnel in the VA system often lag behind those in the private and university sectors. However, all of the cardiac catheterizations and cardiac surgical procedures performed in the VA are performed by qualified specialists, most of whom also have university appointments. Many of these physicians have dual appointments, salaried both through the Veterans Administration and the affiliated university medical school. In a system with 172 medical centers, there are at times instances where VA medical centers lack a sufficient number of cardiologists. Because of the close affiliation with medical schools, the VA system often is helped during a lack of cardiologists or cardiac surgeons. Our Cardiac Surgical Program is performing more than 7,000 open heart and coronary artery bypass graft operations annually.

It is not true that "Many hospitals have to contract for their cardiac surgery in the private sector - - - - - as established VA programs have little or no resources to expand to accommodate more patients". Only two hospitals in the entire VA health care system have contracts with an affiliated university hospital to perform elective cardiac surgery. Three other VA medical centers have contracts with an affiliated university hospital to perform emergency cardiac surgery on those veterans whose condition is so serious that they can not be transferred to another VA medical center with an ongoing Cardiac Surgery Program. Further, it is a policy of the Veterans Administration in providing optimal care to all veteran patients that any VA medical center may elect to transfer a veteran requiring emergency cardiac surgery to a nearby community or university hospital where cardiac surgery can be performed. This only occurs when the veteran is too ill to allow transportation to a more distant VA medical center with an ongoing Cardiac Surgery Program.

The VA has a fine record of safety and productivity in cardiac surgery. No element of health care is monitored with greater precision and sympathy than is cardiac surgery. There are intermittent regional problems in providing cardiac surgical care, but not national problems.

There are some shortages of nurses for intensive care units. This is due to a combination of factors including salary rates. There are not enough nurses in this country and working in any coronary care unit (private or VA) is demanding and many nurses prefer to do other duties.

SENATOR CRANSTON

Question: 4. On page 8 of your testimony, you state that, even though 2,400 beds were closed as a result of the nursing shortage, the department actually treated 4.4 percent more patients than had been predicted in the fiscal year 1988 operating plan. Does it not follow from this that the nurse-to-patient staffing ratio was also lower than planned and that the quality of care might have suffered commensurately?

Answer: The ratio of registered nurses to the average daily census has remained around 1:1.9 since FY'86. We have no information to date to indicate that the nurse shortage has affected the quality of patient care.

Question: 5. On page 14 of your testimony, you state that the agency is considering the recommendations of the Task Force created to recommend options for offsetting the anticipated shortfall and four specific options are described.

A. One option is described on page 14 as the establishment of workload controls, consistent with statutory requirements, to ensure that quality of care is protected. Does this mean that category B and C veterans would be turned away?

B. A second option is described on page 15 as a rigorous review of medical center missions with particular focus on program and management consolidations. Does this include closing facilities?

Answer: 5A. Workload demand on existing facility resources is such that in many locations, admissions for category B and C patients, particularly for elective procedures, will be deferred or referred to community providers. Emergency admissions are accomplished directly or in some cases through transfer to another facility, usually a VA medical center. Outpatient care for B and C patients will be restricted due to resource availability in a similar fashion. The primary goal of workload controls would be to ensure that geographical equity of access would be assured.

5B. The rigorous review that is intended by the statement is that resource demands and changing demographic demands necessitate such a review in order to assure equity of access and quality of care. This does not mean facility closures, but rather that individual programs at certain facilities may be closed in order to assure that the most rational availability of services is accomplished. Management consolidations have been effected in the past for reasons of reduced costs at facilities located in proximity to each other. The rigorous review will facilitate the analysis necessary to determine whether more of these are feasible.

SENATOR CRANSTON

Question: 6. Chart 15, entitled "Fee Basis Visits - Outpatient Medical Care" of the VA Administrator's testimony shows a sharp decline in both the number of visits and the number of treatments for July 1988. What accounts for this significant reduction?

Answer: The number of fee basis visits posted each month is dependent on the number of invoices received each month and the number of visits posted on each invoice.

Month	Visits	Invoices	V/I
June 1988	164,126	100,610	1.6
July 1988	120,563	77,064	1.56
Aug 1988	155,483	97,028	1.6

In looking at the data the number of invoices and the number of visits per invoice were both lower in July 1988. Both returned to normal levels in August. DM&S assumes that this dip in the data is not statistically significant.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

NOV 21 1985

Honorable Alan Cranston
Chairman, Committee on
Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Enclosed please find the Agency's responses to questions which you forwarded on behalf of Senator Graham for the September [illegible], 1985, hearing on VA Health Care. Thank you for the opportunity to provide this additional information for the record.

Sincerely,

THOMAS K. TURNAGE
Administrator

Enclosure

cc: Honorable Bob Graham

SENATOR GRAHAM

General Turnage, in the Paralyzed Veterans of America's testimony before the Senate Veterans' Affairs Committee on September 9, they noted Florida's Gainesville VAMC reports FY88 unfunded operating expenses at over $2 million. They also noted that the Bay Pines, Florida VAMC reports unfunded operating expenses of $1.3 million, in addition to serious shortfalls in that VAMC's ability to provide care to Category B veterans in 20 of the hospital's clinics. The Gainesville Medical Director is quoted in the PVA's testimony as predicting that additional budgetary shortfall would make it "necessary to further restrict delivery of not only prosthetic items, but other direct medical care services in various outpatient care programs." The Tampa James A. Haley Veterans Hospital has shut down 70 beds. And finally, a very successful halfway house in Miami was on the brink of closing because of insufficient funds -- only the intervention of my colleague in the House Representatives, William Lehman, prevented its closing. I bring these unhappy facts to your attention to highlight the problems that exist in Florida. I believe these problems are more than symptoms of a temporary shortfall in the VA's operating budget. I believe these problems reflect the Veterans Administration's constant battle in Florida to provide services for which there is more demand than the system can handle.

The VA is charged under U.S. Code 38 to provide for the equitable distribution of medical facilities and services. The following questions concern the data the VA uses to determine how to "equitably" allocate its resources.

Question: 1. How does the VA statistically monitor the allocation of its medical care resources?

Answer: The initial allocation of resources is done through the RAM (Resource Allocation Methodology). Thereafter, the CALM system (Centralized Accounting for Local Management, electronically based in Austin, Texas, tracks all dollars of expenditure by (in descending order), appropriations, limitation, analysis account, VA medical facility, fund control point and cost center.

Question: 2. Since a significant amount of lead time is required for the VA to register and respond to demographic changes, how does the VA plan for these changes, what statistical information does your agency rely on, and what does the VA expect in the next 20 years to occur in terms of demographic shifts?

Answer: The Veterans Administration uses a variety of statistical resources to plan for the future demographic changes of the veteran population. Perhaps the most important statistical data used for long-range planning are the estimates and projections of the veteran population produced by the Office of Information Management and Statistics. Veteran population estimates are produced each year and are differentiated by age, sex, and period of service for the U.S., Puerto Rico, states (including the District of Columbia), and all counties within states. These estimates are calculated

SENATOR GRAHAM (continued)

using 1980 Census data as the baseline figures, which are updated on the basis of actual separations from the armed forces as reported by DoD, actuarial estimates of mortality by age and sex based on standard U.S. survival rates, and estimates of internal migration based on the Census Bureau's state estimation program. In addition, about every three years, the VA produces projections of the veteran population approximately 50 years into the future. These projections are produced by age, sex, and period of service for the same geographic areas as the estimates. The assumptions underlying the projections include no future conflicts (constant armed forces strength), slowly declining mortality, and interstate migration in the same direction as that observed during the 1980-85 period, but with the levels attenuated over time. Aside from the estimates and projections program, the VA conducts statistical surveys of the veteran population which yield detailed data on veterans' demographic characteristics, benefits usage, and satisfaction with VA services. By comparing the responses across two similar surveys, some indication of change over time can be ascertained. However, survey data do not allow the projection of characteristics, as they represent a detailed snapshot of veteran characteristics at one particular point in time.

Over the next 20 years or so, the current veteran population of 27.3 million is expected to decline to approximately 20.3 million in the year 2010. This decline is due to the excess of veteran deaths--augmented by the increasing mortality of World War II veterans--over the number of separations from the armed forces. While the overall number of veterans will edge downward, the number of elderly veterans is projected to grow dramatically over the next 20 years. The population of veterans aged 65 and over is expected to increase from the September 1988 total of 6.4 million to a peak of 8.9 million in the year 1999 (representing an increase of 39 percent), and then edge down slightly to 8.1 million by the year 2010.

The projected decline in the number of living veterans in future years will not be evenly distributed among states. In general, the Northeast and industrial Midwest will lose the most veterans while states in the South and West will lose the fewest. Veteran deaths outnumber separations from the armed forces in all states and the District of Columbia. As a result, veteran population gains will only occur in those states experiencing noticeable in-migration. Although some states will continue to increase for the next few years due to in-migration, all states except one (Alaska) will show an overall decline by the year 2010.

SENATOR GRAHAM

Question: 3. Did the VA submit to the Census Bureau requests for data to be gathered in the 1990 census in order to help your agency identify demographic trends among the veteran population? If so, what information did the VA request the Census Bureau collect and what was the Bureau's response to that request?

Answer: Over the past three and one-half years, VA representatives have actively participated in several census-sponsored interagency working groups as well as the Federal Agency Council on the 1990 Census; this process has allowed the VA to clearly define and state the Agency data needs as they relate to the 1990 Census. As a result of these meetings, the basic veteran-status question has been retained on the proposed 1990 census questionnaire, including the delineation of active-duty military service by specific period of service. In addition, the 1990 veteran status question has been expanded to clearly delineate persons who are currently on active duty in the armed forces as opposed to those who have separated from military service. Further, service in the Reserves or National Guard is now listed as a separate category to prevent respondent confusion.

An additional period of service category (those serving September 1980 or later) has been added to the 1990 Census questionnaire along with a new question on years of active-duty military service. The addition of these questions will allow the VA to separate out those veterans who entered the military after August 1980 and served less than two years of active-duty military service. These persons were declared generally ineligible for VA benefits under legislation enacted in 1980 and 1981.

The VA was, however, unsuccessful in adding a question addressed to veterans on whether the person ever received a service-connected disability rating from the VA and, if so, whether this was a zero percent rating. Given the difficulty of adding new questions to the basic questionnaire, it was not surprising that these questions were not recommended by the Census Bureau for inclusion. On the whole, the VA was able to retain and substantially improve the basic data to be collected on veteran status in the 1990 Census.

Question: 4. Does the VA have specific standards by which they evaluate the level of care each VAMC is able to deliver? If these standards exist, do they define what is the minimum level of health care resources and the minimum level of health care services offered by a VAMC, below which an inequity in allocation could be identified?

SENATOR GRAHAM (continued)

Answer: The VA has standards developed for the Systematic External Review Program (SERP) which are used both within SERP surveys (approximately every three years for each facility), and as part of a VA medical facilities Systematic Internal Review program. These standards will identify major operational issues at each facility. Additionally, the JCAHO has developed process and structural standards, which the VA uses through a voluntary accreditation process. Either the JCAHO or SERP surveys may identify deficiencies in a facility which may be related to inequities in funding.

Secondly, some highly visible, highly vulnerable programs, such as cardiac surgery, have developed clinical utilization and quality standards and thresholds (such as mortality rates), which are used on a system-wide basis for the review and evaluation of the quality of care. These clinical indicators and criteria may identify deficiencies which maybe related to inequities in allocation.

Thirdly, the VA is currently assessing mortality on a national system-wide basis, reviewing records of VAMCs which appear to have higher than average mortality rates statistically in one or more programs. This may identify inequities in resource allocation.

Finally, the ACMD for Clinical Affairs is currently developing proposals to initiate the development of clinical indicators for all services and programs of the quality, appropriateness and safety of care, which, if funded, will enable the system to have measures of the quality of patient care. One goal of this effort would be to measure the impact of resource allocation decisions on the quality of patient care.

Question: 5. In light of the current shortfall in funds, does the VA intend to evaluate all VAMC's in order to determine which VAMC's are experiencing the most serious problems?

Answer: There is a process, in place, that will identify the VAMC's that "are experiencing the most serious problems". During this critical period, each VAMC will provide advance notification to their Regional Director of any circumstance that could be considered a reduction to previously accomplished workload levels. Each Region will forward a summary of such proposed actions to the VA Central Office to allow evaluation from a nation-wide perspective.

SENATOR GRAHAM

Question: 6. In your testimony before the Committee on September 9 you state that in order to provide care to all veterans to whom the VA has an obligation, "some geographic readjustment of resources may be necessary." Could you please explain what you mean by this comment and how you plan to make these readjustments?

Answer: This statement was made because the Department of Medicine and Surgery believes that access to medical care should be relatively the same in all regions of the country. For instance, Region 3, which covers a great part of the southeastern United States, has the highest percentage of Category A workload. This means that Region 3 treats, on a percentage basis, more Category A veterans than do the other regions. Because of the current funding situation for VA medical care the Department of Medicine and Surgery intends to have all medical centers reduce their non-mandatory workload in order to have their Category A percentage reach the level that is maintained in Region 3. The Department will transfer dollars between regions to achieve the goal of equal access to medical care.

Specific to each VAMC in the VA health care system, I would appreciate it if you would provide me with the following information:

Question: 1. What is the average wait for elective surgery?

Answer: There are no systemwide records kept on a routine basis of waiting times for elective surgery. As one would expect, it varies based on the capacity of the individual VA facility and the type of surgery required. In May 1988, however, our Surgical Service here in Central Office did conduct a one-time random sample of waiting times at 24 VA Medical facilities. The results of that survey indicated that once patients had been evaluated in the various specialty clinics and a decision was made that surgery was indicated, the mean waiting period for entrance into the operating room for all types of surgery was 2.6 weeks. The mean waiting period for cardiac surgery was 4.6 weeks followed closely by orthopedic surgery with 4.1 weeks of waiting prior to entrance into the operating room. There were only 3 outliers of the entire group of 151 specialty services. This included a waiting time of 10 weeks for cardiac surgery in one VAMC and waiting periods of 12 weeks and 25 weeks for orthopedic surgery in two other medical centers.

Question: 2. How much health care is delivered on an outpatient basis when inpatient care was more appropriate, but space or staff availability prevented it?

SENATOR GRAHAM (continued)

Answer: None. Care to eligible VA patients is delivered in the most appropriate mode, based on the medical needs of the patient. The contemporary health care climate, both in the public and private sector, places greater emphasis on ambulatory care. The rising cost of health care in the United States has resulted in the shift of medical care to the outpatient setting. Underlying the financial consideration is the assumption that ambulatory care offers a superior alternative to inpatient care in many circumstances and represents the preferred choice for patients and families.

Question: 3. What percentage of each VAMC's services are delivered to A category veterans? What percentage is delivered to B category veterans? And what percentage is delivered to C category veterans?

Answer: Enclosed are two reports. The report of outpatient visits by facility is for the period October 1, 1987, through June 30, 1988. The report of patients discharged from each facility contains data on all patients discharged during Fiscal Year 1988 whose diagnostic data has been transmitted to the Data Processing Center in Austin, Texas. We realize the Committee requested percentages; however, the information was readily available by the total number of patients discharged by means test category.

I would like to focus now on the future. The VA's current preventive health care program is still a relatively new, but I think important, part of the VA's health care system. Because of the potential for benefits, both in terms of the veteran population's health and in terms of cost-savings for the VA, we should continue to investigate ways to implement preventive health care.

Question: 1. The VA's health care system is primarily a provider of care on demand. Is it possible for the VA to reconfigure its role to allow a greater emphasis on anticipation of veteran health care needs?

Answer: Traditionally the VA has been oriented toward diagnosis and treatment of existing diseases. The VA's preventive medicine program is an attempt to alter this approach by preventing disease through early detection and patient education.

The VA Preventive Medicine Program was mandated by Public Law 98-160 and was implemented by the VA in FY 1985. Continuous progress has been made and each year more veterans are provided preventive medicine services. The Preventive Medicine Field Advisory Group has recommended, through the Chief Medical Director, a list of preventive medicine interventions from which VA Medical Centers could design a local program to meet the needs of their veteran populations. In addition to recommending the provision of services for all interventions listed, a particular intervention is

SENATOR GRAHAM (continued)

singled out for increased emphasis each year. It is hoped that through these highlighted interventions there will be a greater awareness of the importance of preventive medicine in the veteran population.

In FY 1985-86 the special emphasis intervention was immunizations, FY 1987 was colorectal cancer screening and FY 1988 was smoking cessation. For FY 1989 we plan to continue emphasis on smoking cessation, because of its multiplier effect on other risk factors. Additionally, cholesterol screening will be emphasized.

A major preventive medicine program initiative under consideration is the establishment of Cardiovascular Risk Factors Clinics. These clinics would screen veterans for the following risk factors: high cholesterol, hypertension, obesity, and smoking. If two or more risk factors are found, a veteran would be referred to the program. Through intervention, education, and follow-up, a reduction in risk factors should reduce the incidence of cardiovascular disease.

DAV Responses to Questions of
Senator Frank H. Murkowski Ranking Minority Member
Senate Veterans Affairs Committee
Hearing of September 9, 1988

Question:

1. On August 2, 1988, I received a letter from DAV Commander Billy Kirby regarding the funding crisis in the VA.

   A. What are the sources of that information?
   B. How can I be assured the information is valid?

Answer:

The information contained in Commander Kirby's August 2, 1988, letter was derived from a variety of sources. The majority of the information was furnished by DAV National Service Officers in regards to a written request by National Adjutant Charles E. Joeckel, Jr., dated June 30, 1988. The request solicited information concerning instances where VA medical facilities had terminated or restricted services to veterans, as well as delays in processing benefit determinations. Additionally, individual veterans periodically contact us by letter or telephone with specific information concerning their experiences when seeking treatment at VA medical facilities. This information, in broad terms, was also contained in Commander Kirby's letter. Finally, we obtained a draft copy of the, Chief Medical Director Task Force Report On Fiscal Year 1989 Budget and included information from that document in our August 2, 1988 correspondence.

We have no reason to question the validity of information provided by the Veterans Administration, disabled veterans, or by our National Service Officers, who received information from local VA employees and/or veterans.

Question:

2. Was the information that I received provided to Mr. Turnage or Dr. Gronvall? If so, when was it provided? If not, why?

Answer:

Yes. Early September, 1988.

Question:

3. Is the delay in receiving care the same as the denial of care? How would you define each term?

Answer:

In many cases, most definitely. In the context of medical care the providing of appropriate treatment may represent the difference of achieving the cure or stability of certain medical conditions or its exacerbation to a point where severe chronic residual disability ensues. In the most extreme case, it may mean the difference between life and death. (The attached information, as requested in question four (4), clearly illustrates this position).

Question:

4. Does your survey indicate that Category A veterans--those who are required to be provided hospital treatment by VA--are being denied care in VA medical centers? If so, would you provide me with specific documentation which supports your position?

Answer:

Yes. At the September 9, 1988, Senate hearing the DAV provided the committee with a list containing veterans names and documented circumstances of care being denied, or in our view, inappropriate care being provided by the VA. A copy of that list is attached. (A copy is being retained in the Committee file.)

Question:

5. I presented some charts during the committee's hearing (copies of which I have enclosed). Could you please provide your comments to these charts?

Answer:

Initially, it is clear that the VA health care budget has been flat over the last five (5) fiscal years, (FY 85-FY 89) in terms of real dollars, a straight line budget is, of itself, telling. However, ones concern should be heightened when considering the cost of providing quality health care services has steadily risen over the past decade at a rate far greater than comparative inflationary rates for other services and goods. Therefore, a straight line budget actually represents a downward spiraling, decrimental budget.

For years and continuing in Fiscal Year 1989, the VA has consistently operated fewer hospital and nursing home care beds than mandated by law, despite a veteran population that is rapidly aging and placing an increasing demand for both acute and long-term care services. The continued practice of officially operating fewer beds simply equates to a declining number of veterans being able to be treated as the need arises. This becomes more intolerable when the number of "phantom beds" (those officially classified as operational but, in fact, unavailable for different reasons) are considered. Finally, the VA's mandated mission of serving as the primary backup of DOD in the event of war or national emergency is being critically jeopardized.

Although the charts indicate On-Duty Employment Levels of Physicians and Nursing staff has remained relativly stable or slightly increased, it is clear, in our view, a serious crisis exists in the overall level of health care professionals in the VA. The nursing shortage presents the most acute and serious challenge. Clearly, patients seeking care from the VA are older, sicker, and have, as a general rule, a greater number and variety of chronic conditions requiring treatment. This requires they receive more frequent and intense care from nurses who are far too few in number to be able to provide appropriate care. Additionally, some predictions exist that in the year 1990, a large number of experienced VA physicians will leave the system. Clearly, innovative actions must be taken to preserve an adequate number of professional health care providers in the VA.

Question:

6. When did the DAV become aware of the VA funding problems? What did your organization do to bring this issue to light?

Answer:

The DAV has been concerned for years about what we viewed as an inadequate budget for VA health care. We have raised the issue of adequate funding continuously in various hearing testimony before various committees in Congress (Veterans Affairs, Budget and Appropriations). The problems currently confronting the VA and veterans (as focused by the September 9, 1988 Senate hearing) began to surface in a very noticeable manner during early 1988 and have progressed through today. As the funding crisis accelerates the problems expressed by veterans have continued to grow and worsen.

In July 1988, we conducted a survey of all DAV National Service Offices requesting information pertaining to adverse situations impacting VA facilities in their geographical area resulting strictly from inadequate funding. Results of this survey were furnished to all members of Congress in early 1988.

On August 19, 1988, we wrote to all members of Congress alerting them of a list of options developed by VA Central Office to deal with the VA budget shortfall. The results of our survey were published in the September and October 1988 issues of the DAV Magazine which continuously publishes articles regarding the VA health care system as it pertains to both our members and all veterans.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

NOV 1 1988

In Reply Refer To

Honorable Alan Cranston
Chairman, Committee on
Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Enclosed are responses to questions raised by you and Senator Murkowski to Mr. Lindsey following the Committee's September 9, 1988, hearing on the adequacy of DM&S funding. Also enclosed is an updated response prepared by Mr. Lindsey to question 6 of the questions posed in your letter of August 18, 1988.

Thank you for the opportunity to provide this additional information.

Sincerely,

THOMAS K. TURNAGE
Administrator

Enclosures

cc: Honorable Frank H. Murkowski

"America is #1—Thanks to our Veterans"

Senator Murkowski

Question 1: Do you believe that there is a need to examine the mission of the VA health care system in terms of looking at every facility to determine if (1) it's needed, (2) its mission should change, or (3) it could be consolidated with another facility?

-If no, can VA afford to keep doing business as usual?
-If yes, how should such an examination take place?

Answer: Yes, I believe that efforts must continue to be made to relook at the missions of VA facilities. In addition to program specific reviews, I believe that facility missions should be closely examined, with consideration of major mission changes.

In order to pursue effectively an examination of major mission changes, there should be consideration of a national initiative. Recent experience in the MEDIPP process has shown that the question of system "equity" is raised when significant vertical cuts are proposed by Districts/Regions. For example, in the Western Region, a recent proposal to convert the Walla Walla, Washington Medical Center to an outpatient clinic was not successful even though it was approved by the VA Administrator. In the constituent and congressional review of the proposal, a repeated concern was raised as to why Walla Walla was being singled out when there were other facilities in other parts of the country that could also be considered for such a major change in mission. Without a national plan for major vertical cuts, this question could not be adequately addressed.

As input to the Chief Medical Director's Task Force on the Fiscal Year 1989 Budget, one of our recommendations was that the VA pursue an approach similar to a recent initiative from the House of Representatives whereby the Department of Defense could evaluate closure of military bases by use of an external blue ribbon panel. This approach would allow a broad constituency group including members of Congress, veterans service organizations, the AAMC and others to participate and ensure support for any recommended mission changes. Our recommendation was included and referenced in the CMD's Task Force Report as a "Long-Range Strategy" that should be pursued.

Senator Murkowski

Question 2: How much flexibility do you have to reallocate money within hospitals in your Region?

Do you have enough flexibility or is more needed in order to operate the system more efficiently?

Answer: Western Region has flexibility to transfer like kinds of funds (for example, personal service dollars) between facilities. We can also transfer non-recurring funds in limitation .001 between non-recurring accounts with two exceptions: community nursing home and readjustment counseling. These dollars must remain pure and funding cannot be transferred out of these accounts.

All facilities routinely work within a wide range of analysis accounts, floors, and ceilings. Greater flexibility for the medical center would be gained if most/all of these administrative tools were relaxed. This flexibility would give the medical center(s) greater accessibility to all funding and support the concept that highest priorities should be funded first.

Question 3: What is your view of the VA's Resource Allocation Methodology? What changes need to be made in the RAM in order for it to achieve its intended purpose?

Answer: RAM has served to focus attention on improving productivity and efficiency. RAM incentives have resulted, for example, in reduced lengths of hospitalization, expansion of less resource intensive outpatient programs, and overall greater emphasis on analysis of resource utilization. In addition, workload has increased at many health care facilities but medical center management flexibility to continue to provide more services with the same, if not less, resources has been exhausted. Certainly, there is just cause for health care facilities to be concerned with their ability to perform well under RAM through increased workload considering the projected shortfall. This concern should not be considered sufficient justification, however, to totally discontinue using RAM as a management tool. To return to the historical distribution methodology would reduce the need to be concerned about productivity and efficiency, and most likely distribute resources in a less effective and equitable manner. We believe that other actions can be taken to compensate for the pressure to reduce workload, such as capping discretionary workload, which would enable us to continue to utilize RAM as a management tool in the Western Region.

PVA
PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

October 5, 1988

The Honorable Frank H. Murkowski
Ranking Minority Member
Senate Committee on Veterans' Affairs
SR-414 Russell Senate Office Building
Washington, D.C. 20510-6375

Dear Senator Murkowski:

Thank you for your letter of September 15, 1988, regarding the September 9 hearing on issues pertaining to the VA's medical care funding and staffing levels.

I have enclosed answers to your questions which I respectfully request be inserted into the final hearing record.

Sincerely yours,

Gordon H Mansfield

Gordon H. Mansfield
Associate Executive Director
for Government Relations

GHM/df

Enclosures

ANSWERS TO QUESTIONS SUBMITTED BY SENATOR FRANK H. MURKOWSKI
FROM THE PARALYZED VETERANS OF AMERICA
CONCERNING 9/9/88 HEARING

QUESTION

1. Your written statement indicates that you believe that the management of the VA health-care system is too decentralized.

   A. How much flexibility do you believe hospital directors should have in managing resources?

   B. Is it PVA's position that VA hospitals are poorly managed?

ANSWER

On page 5 of our testimony PVA pointed out the direct dichotomy between reports from VA Medical Centers on critical funding shortages (confirmed during this hearing by VAMC field administrators) and the statements of the VA Administrator that the medical system had all the funding it needed. We could only draw the conclusion from this complete contradiction in resource analysis that there was, and remains, a serious lack of communication between VA field stations, VA Central Office Department Medicine and Surgery staff, the VA Administrator and the Office of Management and Budget over what the true needs of the VA health care system really are. We would identify this situation as a serious management problem. Are top level VA managers not receiving reports of budget shortfalls because this information is being "managed" or contained at the medical district or medical region level? Are Central Office Officials receiving these reports, but not believing them? Or, are they just not able to request, obtain and properly distribute sufficient resources to meet these needs?

PVA does not believe that all VA Medical Centers are poorly managed, nor did we attempt to imply that in our testimony. We merely stated, as indicated by this situation, that there appears to be a growing lack of communication between the field and the VA Central Office which has been compounded by growing administrative separation between the two entities. A degree of flexibility is certainly prudent in allowing medical center directors to manage resources, particularly when those funds are in increasingly short supply. However, such "flexibility" should not allow individual stations to independently ration or curtail health care services for eligible veterans to stretch shrinking budgets in violation of the intent of the law because they are not able to request or receive the dollars they need. Likewise, as we also stated in our testimony, the Central Office should have the ability and the resources itself to monitor, identify, and respond in a timely fashion to funding shortfalls when they occur.

QUESTION

2. In times of severe budget deficits, some agencies would be more than pleased to report that they maintained a constant budget. Yet the veterans' organizations are not pleased with this result.

   A. Would you like to respond to the statement that the VA has been given priority funding and constant budgets while other important Federal programs are experiencing significant cuts.

ANSWER

Unlike most other federal agencies, the Veterans Administration, particularly in the area of health care, is a direct service provider with a specific mission and a specific clientele established by law.

Certainly, as the needs of that population change or increase and the provision of these services grows more expensive, the VA, as required by law, must receive sufficient resources to meet established health care requirements, standards and entitlements. For this reason it is not possible or realistic to attempt to compare the adequacy of VA budget requirements with funding levels for most other federal agencies or departments which merely manage the procurement and distribution of benefits and not the direct provision of them.

The Department of Defense can eliminate a weapons system. HUD can eliminate Urban Development Action Grants. Education loans or loans to small businesses can be restricted. The impact of these cuts, while potentially damaging, is based on changing political priorities, shifted to other existing resources or generally borne by society at large. On the other hand, a Category A veteran with a service-connected heart condition in acute need of open heart surgery must be assured that he or she has access to that treatment in a properly equipped hospital with modern medical equipment and supplies, adequately trained and experienced doctors and nurses, proper prescriptions and drugs, appropriate post-surgical care and rehabilitation services. This is a matter of life or death. The current state and cost of modern medicine should drive VA budget levels in order to maintain the quality of health care and the quantity of that care prescribed by law, - not artificial budget base lines. Unfortunately, the cost of that care has risen proportionately with the current price of modern medicine and the increasing demands of caring for larger numbers of frail elderly veterans. Some might be pleased that, in comparison with some other federal agencies, the VA has maintained "constant" budgets. But, in our opinion, and in the opinion of most of those who testified at this hearing, those budgets have not been adequate to meet a cost for services which has not remained constant but has risen dramatically in recent years.

To further address your question, however, PVA, earlier this year, published a comparative analysis of total federal health care expenditures and VA health care budgets over the past several years. A copy of this document entitled "Federal Health Budgets and Health Care for Veterans" was presented for the review of this Committee at that time. The analysis clearly showed that VA health care expenditures in recent years have fallen far behind the general rate of increase and adjustment enjoyed by all other federal health care programs.

For instance, if veterans' health care had been given the same relative proportion of the health care budget as the average increase for all functions (+6.44 percent), the President's budget for VA medical care would have been $11,302 billion, or $492 million higher than that presented to Congress. This approximates the total amount of funding recommended in the Independent Budget for FY'89.

If the veterans' health care budget received the same relative proportion of the federal health budget as in FY'85, the President would have requested

$12.2 billion for FY'89, or $1.4 billion more than the FY'89 request--a request more in line with the current budget requirements of the agency. It should be noted, however, that the VA health care budget has been inadequately funded over the entire period of this and prior Administrations so that current service funding requirements are considerably understated.

We have attached an additional copy of this document for your further analysis.

QUESTION

3. I presented some charts during the Committee's hearing (copies of which are enclosed). Could you please comment on those charts.

ANSWER

Chart 1: "Medical Care Budget Authority
Current vs. Deflated (1977) Dollars

The chart indicates that in terms of 1977 dollars the VA Medical Care Budget has remained level despite the spiraling cost of health care and the increasing cost of providing more extensive and expensive treatment for increasing numbers of frail elderly veterans. The House Committee on Veterans' Affairs during hearings on September 14, 1988, on the adequacy of VA health care resources used the same chart very effectively, in our opinion, to indicate the deterioration of VA health care resources and the purchasing power of the VA health care dollar over this period of time.

We have also prepared three charts which compare VA funding, in terms of 1977 deflated dollars, with the number of VA inpatients, outpatient visits and nursing home patients treated from 1980 through 1989 as projected by the Veterans Administration. All three charts graphically illustrate the dramatic increase in the number of VA patients being treated over this period of time while the purchasing power of the health care dollars to provide that care has remained virtually constant. As these figures indicate, the VA is consistently being asked to do more with less. If this trend is allowed to continue, the system very well might reach a breaking point seriously jeopardizing the overall quality of care at most VA medical centers. Judging from the testimony we heard at this hearing, the health care system in many areas has already reached this crisis point. We respectfully request that these charts be included in the hearing record.

Chart 2 & "Average Daily Patient Census by Bed Type"
Chart 3 and "Average Number of Operating Beds
by Type of VA Hospitals"

The Veterans Administration, in recent years, has made a definitive effort to cut costs by reducing both length of stay and average daily patient census shifting more patient care to outpatient services. In our opinion this shift has been driven by both RAM adjustments and DRG models as well as lack of personnel to adequately staff hospital beds and wards in many Medical Centers. The total number of operating beds over the past twelve years has decreased dramatically. This reduction is certainly responsible for the agency's ability to absorb most of the cumulative budget reductions they have experienced. However, while the number of beds may have declined, the number of admissions and the number of veterans treated has increased dramatically. Hence, more patients, requiring more care per day, are being treated in fewer beds. It is clear, however, that this shift in services, which has already begun to severely strain out-patient capacity, can no longer continue without dramatically eroding quality of care. Bed closures, and early discharges, without adequate follow-up or home treatment, can be just as damaging as overworked or overbooked outpatient clinics and staff. At the same time, the agency is making very little effort to identify or provide resources for existing beds, now closed, to help meet the dramatically increasing long term care needs of a rapidly aging veteran population.

Chart 4

By all reports RN to patient and RN to bed ratios in the Veterans Administration are considered quite low in comparison with other non-VA hospitals. The chart indicates that the total number of nurses in the VA has remained almost static over the past eight years despite the expansion of the system through new activations, new entitlement eligibility for health care and increasing demands placed on all health care professionals by the increasing and intensive medical needs of an aging veteran population. We find this shortage of nurses compounded by the national nursing shortage to be a serious problem facing the VA.

QUESTION

4. Is delay in receiving care the same as denial of care? How would you define each term?

ANSWER

If the VA intentionally delays medical services or the provision of prescribed medical prescriptions, equipment and supplies for an eligible veteran with an identified medical need because funding is not available to provide those services in a timely or medically appropriate fashion, PVA would consider this to be denial of care.

QUESTION

5. When did the Paralyzed Veterans of America become aware of the VA funding problems? What did your organization do to bring this issue to light?

ANSWER

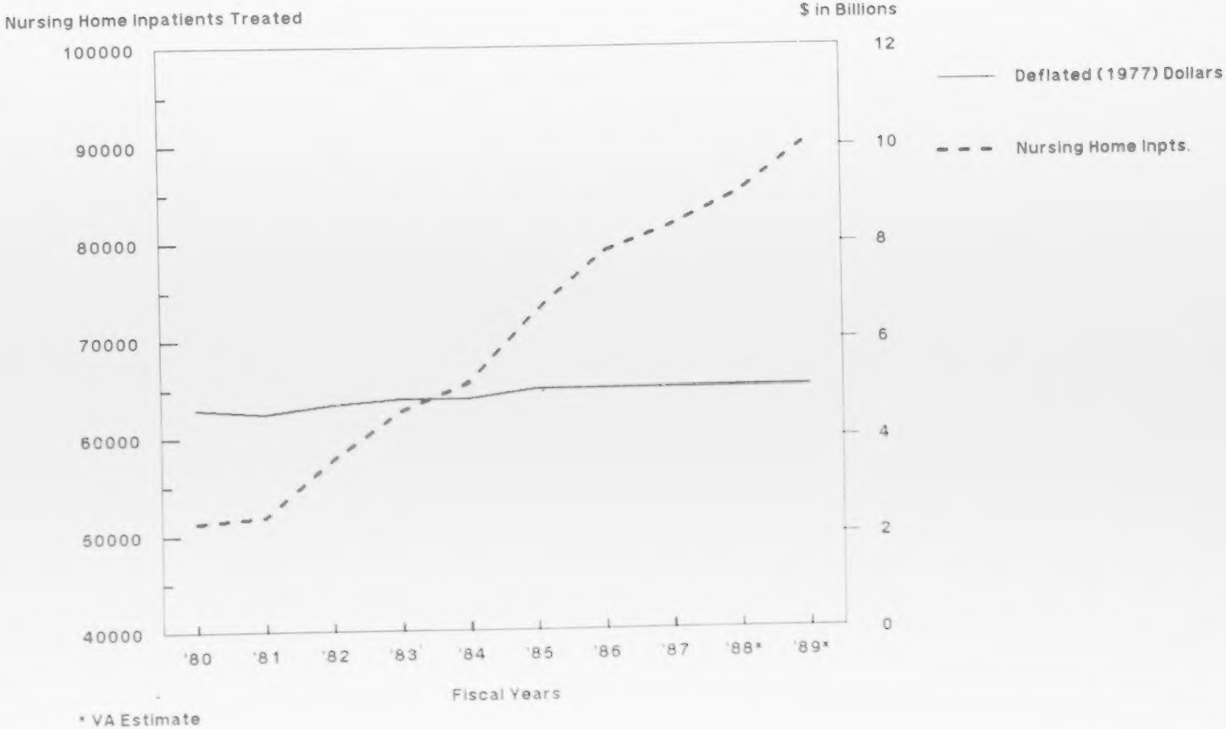
Paralyzed Veterans of America, over the past ten years, has regularly, repeatedly and consistently expressed its concern over the adequacy of VA health care resources to this Committee, the House Veterans' Affairs Committee, the House and Senate Budget Committees, the House and Senate Appropriations Committees and to the House and Senate as a whole. We have specifically identified and opposed decremental VA budgets and budget proposals which have not kept pace with current or anticipated demand. We have testified, repeatedly before this Committee, and in great detail over the past four years alone, over the impact these reductions are having on the ability of the VA to maintain the quality and quantity of care. The "Independent Budget for Veterans Programs" prepared by four major veterans' service organizations, including PVA, for the past two years and presented to Congress has clearly identified and documented instances where scarce medical resources are forcing VA Medical Centers to restrict access to needed medical services. The "Independent Budget for FY 1989" presented to this Committee in February, 1988, specifically listed the results of a sample survey of VA medical center directors and chiefs-of-staff which clearly demonstrated that certain forms of care were being rationed in VA medical facilities because of lack of resources.

Quite frankly, PVA is surprised to have to repeat this information here. But for your review again, we would like to submit copies of our Annual Testimony presented to this Committee in 1985, 1986, 1987 and 1988 as well as our testimony on the VA budget presented to the Committee in 1985, 1986, 1987 and 1988. Also attached for your information are copies of "An Independent Health Care Budget for Veterans, 1987" and "An Independent Budget by Veterans for Veterans' Programs, 1988."

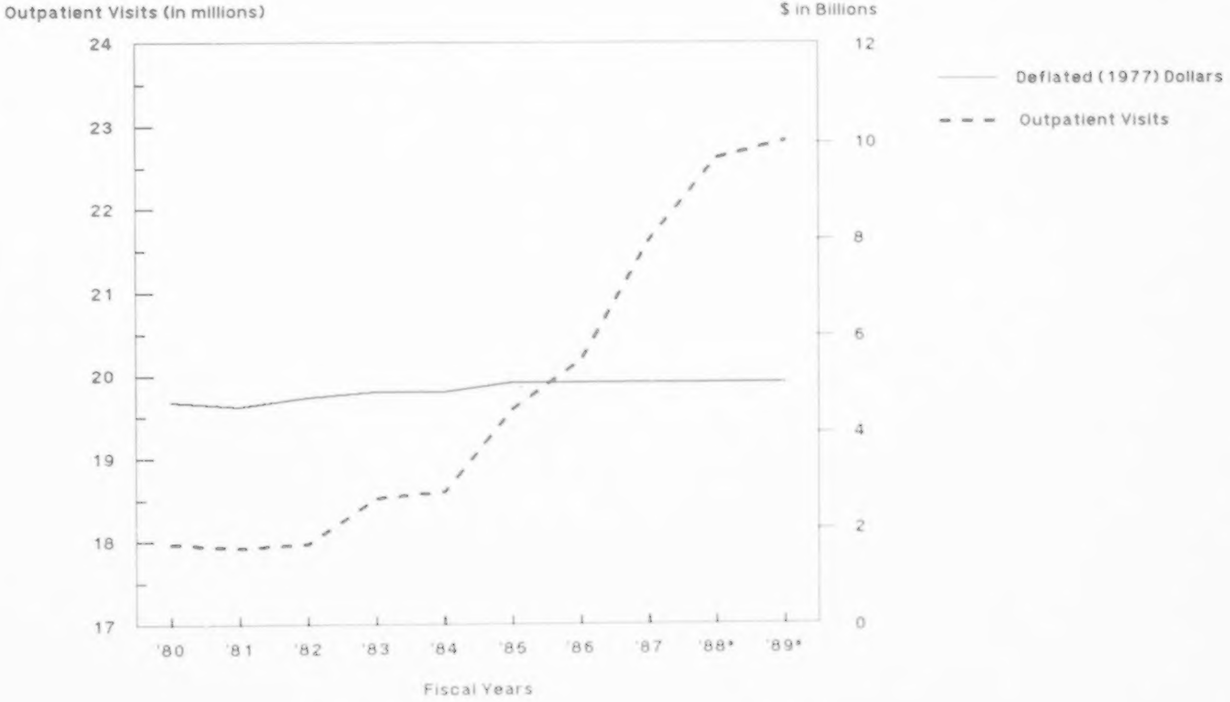
RBF/df

[Enclosures retained in committee files.]

Medical Care Budget Authority vs.
Nursing Home Inpatients Treated

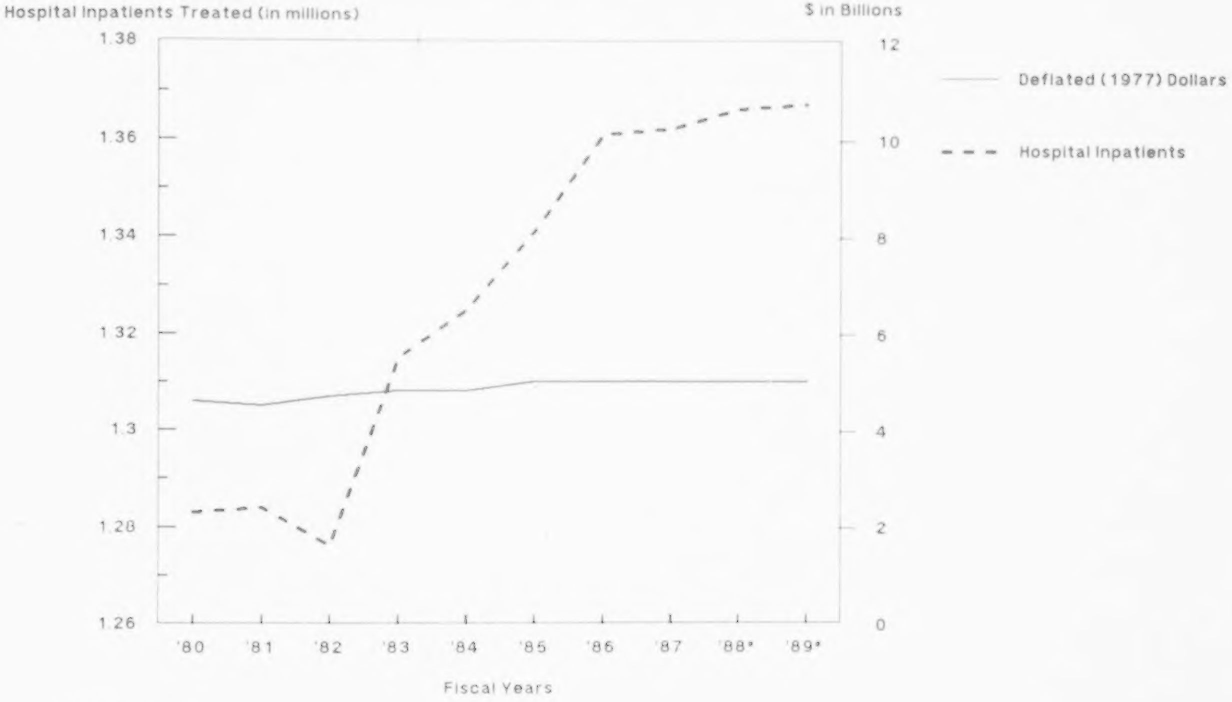


Medical Care Budget Authority vs. Outpatient Visit Workload



* VA Estimate
Note: for purposes of comparability, dialysis treatments are included in hospital inpatients treated for all years

Medical Care Budget Authority vs. Hospital Inpatients Treated



* VA Estimate

Note:for purposes of comparability, dialysis treatments are included in hospital inpatients treated for all years

The
American
Legion

For God and Country

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October 4, 1988

Honorable Frank H. Murkowski
Ranking Minority Member
Committee on Veterans Affairs
United States Senate
Washington, DC 20510-6375

Dear Senator Murkowski:

This is in response to the questions relating to the Committee's September 9, 1988 hearing on VA medical care funding, which you submitted in your recent letter to Executive Director Mylio S. Kraja.

1. The evidence that the quality of care is eroding - based on inadequate funding - is documented throughout our statement. In addition, we continue to receive telephone calls and letters from our Department Service Officers and other interested American Legion officials, regarding the multiple problems that are occurring throughout the VA medical care system. This includes the closing of beds, increased waiting times for outpatient treatment, admissions and surgery, closing of clinics, elimination of treatment for some nonservice-connected veterans, reduction of the availability of prescription drugs, and the list goes on. These are examples of what is meant by the erosion of the quality, quantity and timeliness of health care services provided to veteran beneficiaries.

2. Delay in the furnishing of care may well be defined at least as a temporary denial of care. In addition there is no doubt that some veterans, when faced with delay in the provison of care, will tend to evade the bureaucracy and end up without treatment.

3. Yes. We have received reports from Department Service Officers, Hospital Volunteers and other interested Legionnaires that there are Category A veterans - particularly those who are seeking treatment for nonservice-connected disabilities or diseases - who are being denied care. As was stated during the September 9th hearing, we are going to elicit additional information from the field on the extent of this and other problems relating to the VA medical care system.

4. The American Legion continues to be adamantly oppposed to the means test. Having said that, we totally support the provision of medical care to the nonservice-connected veterans with incomes below the levels established pursuant to PL 99-272, and the other veterans who have been accorded entitlement to such treatment. Therefore, we oppose the aforesaid proposal.

5. The American Legion has long been aware of the decremental funding that has been provided the VA Department of Medicine and Surgery as is evidenced by the concerns expressed regarding specific programs in our testimony presented to this Committee over the years.

We became aware of the extent and nature of the problems that are now developing as a result of the funding shortages in April of this year, when we received the first telephone call regarding the elimination of treatment to Category B and C veterans at a medical center. Subsequent to the first call, we began receiving numerous calls from around the country regarding the actions that were being taken to reduce spending by individual medical center directors.

We initially attempted to get individual responses from the Department of Medicine and Surgery regarding the different attempts at cost-savings. When it became apparent that the problems were widespread and their impact was significant, we contacted the Administrator's staff to discuss the situation. In addition, then National Commander John P. "Jake" Comer co-signed a letter to the Administrator along with two other National Commanders, expressing concern about the funding shortfalls, and the resultant impact on the VA medical care programs.

The responses received were that in essence there was no problem, and that adequate funding was available.

Thank you for your continued interest in the views of The American Legion on this important issue.

Sincerely,

JOHN F. SOMMER, JR.
Director
National Veterans Affairs and
Rehabilitation Commission

Veterans
Administration

SEP [illegible] 1988

In Reply Refer To:

Senator Frank H. Murkowski
United States Senate
Committee on Veterans' Affairs
Washington, D.C. 20510-6375

Dear Senator Murkowski:

This is in response to your letter dated September 15, 1988 which transmitted three additional questions in follow-up to the Hearing on September 9, 1988. My responses are enclosed.

I appreciate the opportunity to respond to the questions and appear at the September 9th Hearing.

For And In The Absence Of
DONALD B. THOMPSON

Enclosure

Questions Submitted by Senator Frank H. Murkowski
for Donald B. Thompson
in Connection with the SVAC Hearings
September 9, 1988

Question #1: Do you believe that there is a need to examine the mission of the VA health-care system in terms of looking at every facility to determine if 1) it's needed, 2) its mission should change, or 3) it could be consolidated with another facility.

- If no, can VA afford to keep doing business as usual?

- If yes, how should such an examination take place?

Response: In my opinion, we must continuously examine the need for individual VA Facilities and their missions. I personally don't believe that facility consolidations save much with respect to operating costs, but consolidations or specialization of services to be provided in those facilities often can improve efficiency.

DM&S has in place the mechanisms to accomplish such reviews and has done so with regularity since 1984. Our Strategic Planning Program (MEDIPP) is the perfect avenue to consider such matters. MEDIPP is demographically based and designed to study trends in VA health care delivery, along with projecting long range needs for services. I believe that the strength of the MEDIPP process is it's extensive data base and grass roots approach. Those closest to the delivery of care are therefore responsible for developing a long range strategy which is reviewed and approved at higher organizational levels.

Since the beginning of MEDIPP, we have proven that we are not maintaining a "business as usual" approach. One only has to look at the changes in practice from expensive inpatient programs to less costly alternatives and outpatient care to understand we are providing more care to more veterans without having received significant increases in resources. Further, we have implemented more than 200 MEDIPP initiatives from our existing resources. We are proud of our productivity performance.

Question #2: How much flexibility do you have to reallocate money within hospitals in your region?

- Do you have enough flexibility or is more needed in order to operate the system more efficiently?

Response: With a few exceptions, I have the flexibility I need to make adjustments within the Region from the total resource pool provided to me at the Regional level. A number of accounts are fenced, or identified for specific use either through Legislative language or VA's internal accounting and I must abide by these restrictions.

The biggest difficulty I have faced since becoming Regional Director in 1982 is that demand for care has been increasing beyond the rate of resource growth in the Region. I have redistributed resources within the Region over the last 6-7 years, but this has not kept pace with veterans migrating south and creating increased demand for services.

Increased flexibility in certain areas would, in my opinion, permit us to operate the system more effectively. For example, relief from items such as personal services floors and employment ceilings would permit a better balance between operating funds and those that must be devoted to salaries.

Question #3: What is your view of the VA's Resource Allocation Methodology? What changes need to be made in the RAM in order for it to achieve its intended purpose?

Response: I feel that RAM has been an extremely valuable management tool that could have been perhaps more effective if checks against incentives for growth in workload had been built in, and if resources had flowed between facilities without being capped. The capping was applied to avoid "wrenching" particular medical centers that would have experienced rather large resource losses. We clearly would not want to effect massive shifts in resources in one year. However, capping of the resource shifts has continued, allowing less productive Medical Centers to retain portions of their "unearned" resources. I believe this situation widened the geographic differences in access to care which pre-existed the RAM by permitting these Medical Centers to achieve higher discretionary type workloads with funds that were retained. Facilities having resource gains, which were also capped under RAM, never got the full level of their earned resources to permit them to increase their workloads accordingly.

In any discussion of RAM we must remember that RAM is not a reimbursement mechanism as used in the private sector or by HCFA. It is an allocation tool used to distribute a basically static pool of resources. I believe that current budget realities make RAM of little use beyond an indicator of relative productivity. Medical Centers will assuredly have to control workloads under the present budget picture for FY89. Once the geographic access disparities are equalized nationally, RAM can continue as an extremely valuable management tool.

In summary, incentives to create additional workload should be held in check and caps removed so funds can shift toward more efficient Medical Centers.

**Office of the
Administrator
of Veterans Affairs**

Washington DC 20420

**Veterans
Administration**

FEB 15 1989

In Reply Refer To:

Honorable Frank Murkowski
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Senator Murkowski:

Enclosed please find the Agency's responses to questions raised by you following the September 9, 1988, hearing on the Veterans Administration's medical-care funding and staffing levels. A copy of these responses has been provided to Senator Cranston for inclusion in the hearing record. Thank you for the opportunity to provide this additional information for the record.

Sincerely,

Thomas E. Harvey

THOMAS E. HARVEY
Acting Administrator

Enclosure

"America is #1—Thanks to our Veterans"

SENATOR MURKOWSKI

Question:	1. The August 4, 1988 Department of Medicine and Surgery (DM&S) Task Force report indicates a fiscal year 1989 shortfall of about $819 million.
	1a. Who came up with this figure?
Answer:	The Office of Resource Management in the Department of Medicine and Surgery during the FY 1989 Target Allowance process.
Question:	1b. Specifically, how was it derived?
	1c. On what assumptions is it based?
Answer:	The following chart lists the specifics making up the shortfall.

Medical Care
FY 1989
($000)

Item	Shortage Amount
I. Items Affecting the Base Each Year	
A. 1% Productivity Reductions to the Budget:	
1. FY 1988 1% Productivity	33,297
2. FY 1989 1% Productivity	65,114
B. Imposed Savings	
1. Standardization in Supply	3,100
2. DHCP Savings	7,900
3. CALM Savings	50
C. Payroll-Related Absorptions	
1. Absorption of Within-grades	58,907
2. Absorption of 88 FEHB	18,122
D. Contract Hospital Per Diem	47,867
II. New Mandates and Initiatives	
A. MEDIPP/Contingency	
1. New MEDIPP Initiatives	20,000
2. Contingency for RAC	17,000
B. New Programs Mandates by other than P.L. 100-322	
1. Homeless Chronically Mentally Ill	7,932
2. Homeless Doms	10,367

SENATOR MURKOWSKI (continued)

Item	Shortage Amount
C. New Fiscal Requirements	
1. Deficit in Special pay FY88	25,000
2. Special Pay in Target Allowance	42,000
3. Special Pay not in Target Allowance	55,208
4. Absorption of Pay Raise	121,496
5. Restoration to AIDS Impacted Facilities	34,437
6. Mandated P.L. 100-322:	
a. Outpatient Services	21,054
b. Dental Care for POW's	279
c. Readjustment Counseling	4,700
d. Beneficiary Travel	43,298
e. Congressional Report	1,500
f. AIDS Prevention	7,130
g. Saturday Premium Pay	19,400
h. Standardization	112
7. Unmandated P.L. 100-322	153,982
TOTAL	819,252

Question: 2. During the hearing, Dr. Gronvall stated that a revised shortfall figure of $608 million is a more accurate reflection of the actual shortfall. Mr. Administrator do you endorse this figure? If so, why? If not, why not?

Answer: After a close review of the situation and considering recent Congressional action on the VA 1989 Appropriation bill, we estimate the projected shortfall to be $432 million. This estimate is, of course, under continuous review and is subject to further revision. A discussion of the shortfall estimates is provided below.

One cause of this shortfall is the enactment of P.L. 100-322 "The Veterans' Benefits and Services Act of 1988". Just the mandatory cost to the VA is $106 million over what was appropriated for FY 1989.

Further Federal Employee Health Benefit cost increase of 26 percent will require another $61 million.

The additional costs of the Federal Civilian Pay increase from 2 percent to 4.1 percent will cost $86 million. Congress has given VA the authority to request this funding in a supplemental appropriation.

SENATOR MURKOWSKI (continued)

Special Pay rates for nurses and other scarce medical specialties and within grade increases paid in accordance with regulations and law to all eligible employees who perform at acceptable levels will cost an additional $75 and $59 million respectively. The budget anticipated absorbing the $59 million within grade cost through filling of vacancies at lower grades. This cannot be achieved as the average GS grade in Medical Care is only 6.5. (This average is significantly below the Government-wide average grade of 8.5.)

Unbudgeted costs for AIDS and universal precautions are expected to increase requirements by $45 million. The universal precautions proposal for $25.8 million was not included in the $608 million figure originally discussed by Dr. Gronvall.

In summary, the requirement to cover this shortfall is $432 million. DM&S medical centers cannot absorb all these costs through reprogramming.

This amount is $202.3 million below that which the Chief Medical Director (CMD) alluded to in the following areas:

- o The restoration of the productivity shortfall of $98.4 million is unnecessary due to congressional action which established the Medical Care employment level of 194,720. This action, in my opinion, restored the effect of the productivity proposals.

- o Contract Hospitalization of $47.2 million is not required due to the implementation of new pricing regulations that are the same as for Medicare. These new regulations are expected to be in place January 1, 1989.

- o Special Pay is $22 million less than the additional $97.2 million. The allowance of $75 million provides for coverage of the 1989 requirement of $55.2 million and partial recovery of last year's absorption of the unfunded special pay requirements.

- o The Homeless Programs funding request $23.6 million has been offset within existing funding.

- o The VA has undertaken automation of the hospital system with the DHCP program and CALM improvements. The savings of $11 million attributed to these types of improvements are still valid.

SENATOR MURKOWSKI

Question: 3a. Some medical centers argue that the VA has not kept pace with the medical CPI (Consumer Price Index). Is this statement true?

Answer: Each year when the VA budget is developed, inflation is added as an uncontrollable item. It is calculated based on the Administration's current economic assumptions. These economic assumptions are used by all Executive Branch agencies to budget for inflation. In the Medical Care appropriation, both a medical and non-medical CPI is applied. Contracts, supplies and equipment are adjusted by the medical CPI, while all other non-personal service items are increased by a non-medical index.

The chart below is the result of applying both indexes (medical and non-medical) to the prior year base of obligations for fiscal years 1984 to 1987. The resulting composite index percentage change for both budget and actual is compared. A negative percent indicates that the actual inflation was higher than that projected in the budget.

Fiscal	Composite CPI		
Year	Budget	Actual	Difference*
1987..........	5.6%	6.1%	-0.5%
1986..........	6.0%	6.5%	-0.5%
1985..........	5.0%	5.5%	-0.5%
1984..........	5.0%	5.8%	-0.7%

*Chart may not add/subtract due to rounding.

Question: 3b. Does the VA, because of its size and purchasing power, really need to keep up with the medical CPI?

Answer: The Medical Care appropriation requirements must keep pace with the composite of both the medical and non-medical CPIs. Since budgets are built on a prior year base, purchasing power has for the most part been reflected and carries forward into the budget year. For example, the projected cost of drugs in 1989 is based on actual 1987 experience which would have recognized purchasing power, economies of scale, etc.

SENATOR MURKOWSKI

Question: 4. The House Veterans' Affairs Committee recently published a survey of VA hospitals which contained a question regarding needed VA staffing increases which would be needed to bring VA levels up to those of the community.

A. What is your opinion on this issue. That is, should these levels be similar? If not, why not?

Answer: There are factors which impact on the staffing in VA hospitals which are not present in the community. For example, VA by law is required to treat a population which may or may not parallel that in the community. Staffing levels in VA are determined by patient acuity, which generates the workload. If the patient acuity profile in a VA hospital is similar to those in the hospitals in the community, all else being equal, then the staffing levels should be similar.

Question: 5. In your view should VA be building new hospitals -- like that in Palm Beach -- when the VA is having some difficulty in staffing the existing VA facilities?

Answer: The staffing difficulty should not be the issue, but whether or not there is a patient population that should be served. If demographics and other factors indicate the need for a hospital, clinical addition, or outpatient clinic, etc., to care for veteran patients, then it should be built and funds provided to staff it appropriately.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

February 22, 1989

The Honorable Frank H. Murkowski
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Senator Murkowski:

Please find enclosed the Veterans of Foreign Wars response to questions submitted by you with respect to testimony given during the Senate Veterans' Affairs Committee hearing held September 9, 1988.

With best wishes and kind regards, I am

Sincerely yours,

DENNIS M. CULLINAN, Assistant Director
National Legislative Service

daa

Enclosure

★ WASHINGTON OFFICE ★
VFW MEMORIAL BUILDING ● 200 MARYLAND AVENUE, N.E. ● WASHINGTON, D. C. 20002 - 5799 ● AREA CODE 202-543-2239

QUESTION 1. You state that the VA has misled the veteran public with respect to the number of beds being operated by the VA.

A. Specifically, how did this misleading occur? That is, did the VA tell you or any other organization that indeed it was operating 90,000 beds?

RESPONSE 1. In response to this question I will quote in part from the VFW statement delivered before the Senate Veterans' Affairs Committee on September 9, 1988:

"There has been reference within the VA for several years to the concept of 'phantom beds.' Phantom beds are those which are officially listed on paper as operating beds for the purpose of complying with the requirements contained under Title 38, USC, but which are actually not staffed and available for patient care. By far and away and despite official denials, the primary reason for the large discrepancy between paper and actual operating beds, 'phantom beds,' is the lack of personnel to staff them. This has been borne out through the site visits of our VFW Field Representatives, as well as by other informational sources available to us.

"As you know, a report from the recent site visits to 16 VA medical centers by a group of House Veterans' Affairs Committee staff members provides graphic evidence of the problem. Of the 14,939 beds authorized through the 16 visited VAMCs, 12,960 were officially counted as operating, that is available for veteran's health care. However, from out of this reduced total only 11,011 were actually available or operating. So just within those 16 VA hospitals, we have a total of 1,949 'phantom beds' of which 1,771 were identified by hospital management as closed due to insufficient staff. Of course, the problem of closed beds is not the same at all hospitals; three individual hospitals within the survey have no bed shutdown due to staff shortages. The report indicates the proportion of operating beds which are closed due to inadequate staff at the individual hospitals range from 2.5 percent to 36.3 percent. But, taken as a whole, the problem is very serious indeed. In hospitals that do have staff shortages leading to closed beds, the average proportion of operating beds which are not adequately staffed 'phantom beds' is 19.1 percent. As it now stands, there are considerably fewer operating beds within the VA system than are authorized, and of that reduced number a substantial percentage would seem to be 'phantom beds' which exist only as a statistical fiction rather than as an actual health care resource."

It now bears mentioning that the recent "Survey of Veterans Administration Medical Centers" conducted by the House Veterans' Affairs Committee addressing this and other issues indicates that throughout the entire VA system 13,039 hospital beds are reported "temporarily out of service" as of June 30, 1988. Thus more than 13,000 VA hospital beds are not actually available for the provision of health care in addition to the several hundred beds which are officially recognized as unavailable for service due to a variety of reasons. Where the VA has consistently maintained that they are only several hundred beds below the 90,000 bed floor, the actual number of beds unavailable for the provision of health care has been well in excess of 13,000. Therein lies the deception.

QUESTION 2. I understand that VA hospital directors who testified before the House Committee on Veterans' Affairs on Wednesday stated that bed levels are not an appropriate way to measure the quantity of care provided to veterans.

A. Does the VFW believe we should measure the availability of care in terms of operating beds? If so, why?

RESPONSE 2. While bed levels are important in determining the quantity of care which is available to veterans, it should not be viewed as the sole criterion in the equation. Also of major importance is the availability of outpatient care capability as well as the availability of numerous other services and assistance for veterans as well as the maintenance of an up-to-date physcial plant and the inventory of all necessary supplies and medicines.

QUESTION 3. You state in your testimony that if there were more VA beds available then the patient census would be higher.

A. What evidence do you have to support that statement?

RESPONSE 3. As was stated at the hearing and as is available in the addendum to the statement for the hearing of September 9, 1988, the VFW and others have recorded numerous instances of veterans being denied care (through delay or referral to a non-VA provider) for lack of resources by the VA. It is clear to us that if these and other veterans were treated by the VA that the VA's patient census would, in fact, be higher. Also, as indicated in our statement, the VA's "phantom beds" are not only reducing its current health care capability but are also contributing to the further erosion of the VA health care system by creating the harmful and deceptive appearance of a low patient census.

One now familiar OMB ploy to justify reducing the VA's health care capability is to cite the relatively low average daily inpatient census, roughly 55,000, for the VA nationwide. However, with beds officially "operating" on paper but actually unusable, it is no surprise that VA occupancy rates appear to be low. The demand for health care from the VA by veterans is rising and will continue to rise, and it is the VFW's contention that if there were more VA health-care beds actually available and operating, the patient census would be considerably higher. By reducing the VA's actual ability to provide health care and thereby artificially reducing its workload, OMB has fabricated the justification to further reduce VA health care capability.

QUESTION 4. Is delay in receiving care the same as denial of care? How would you define each term?

RESPONSE 4. If a veterans is in need of care and is told by the VA that he should either seek that care elsewhere or come back at some other time when the resources are available, yes, the VFW deems that to be the denial of care. If a veteran is not provided care on a timely basis as needed then he or she has ,in fact, been denied care.

QUESTION 5. When did the VFW become aware of the VA funding problem? What did your organization do to bring this issue to light?

RESPONSE 5. A review of the VFW's testimony addressing the VA budget over the past years shows our awareness of the problem. It is a matter of record that we have appeared before the Congress on numerous occasions to bring this issue to light. We have also kept this serious matter before the public eye through a number of VFW publications as well as press releases and articles written for the general public. For the second year the VFW has joined in a cooperative effort with three other veterans organizations to develop and present to Congress an Independent Budget (IB) addressing program requirements of the Veterans Administration. The serious erosion of the discretionary components of the Veterans Administration budget, primarily the health care budget, are the primary concerns articulated in the Independent Budget. Thus, we have labored long and hard in order to not only bring this problem to light, but to have it rectified as well.

VIETNAM VETERANS OF AMERICA
[illegible]
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Suite [illegible]
Washington DC [illegible]

(202) 33[illegible]700

September 27, 1988

Senator Frank H. Murkowski
Ranking Minority Member
Senate Veterans Affairs Committee
SH-202 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Murkowski:

This letter will respond to your September 15 communication to Mary R. Stout with follow-up questions arising from the Committee's September 9 hearing on health care resources. Naturally we welcome the opportunity to address these questions and appreciate your thoughtfulness in bringing them to our attention. Each of your questions will be addressed in turn.

1. You stated in your testimony that it is impossible for the very highly centralized VA health-care system to provide quality health care. Yet we heard the PVA state that the VA system was too decentralized.

   What is your reaction to the PVA position on this issue?

   OUR UNDERSTANDING IS THAT PVA WAS REFERRING TO VA's INABILITY TO ORGANIZE ITS DECISION-MAKING PROCESSES AT THE LOCAL LEVEL IN SUCH A WAY THAT IT WOULD NOT BE NECESSARY TO REQUIRE THE ASSISTANCE OF ELEMENTS HIGHER UP IN THE CHAIN OF COMMAND SUCH AS THE DISTRICT, THE REGION, OR VACO ITSELF. IN SUCH A SITUATION THE SYSTEM WOULD INDEED, BE TOO DECENTRALIZED.

2. You support the elimination of VA medical regions. What would be the objective of such an action?

   THE OBJECTIVE IS TO FACILITATE DIRECT INTERACTION BETWEEN THE VAMC AS PROVIDER OF HEALTH CARE AND VACO AS PURCHASER (FIDUCIARY INTERMEDIARY). THIS ACTION WOULD BENEFIT THE VETERAN BY REDUCING UNNECESSARY ORGANIZATIONAL LAYERING WHICH LEADS TO REDUCED ACCOUNTABILITY. THE PROVIDER/PURCHASER RELATIONSHIP CAN BE HANDLED AT THE DISTRICT LEVEL.

ADDITIONALLY, AS NOTED IN THE TESTIMONY, THE REGIONS TEND TO BE USED BY VACO TO DENY CORPORATE RESPONSIBILITY AND ACCOUNTABILITY.

FINALLY, THE REGIONS THEMSELVES HAVE BECOME TOO POLITICIZED IN THE SENSE OF BEING SEVEN "MINI" VACO (REGARDING RAM PARTICULARLY) AT THE EXPENSE OF THE MEDICAL CENTER DIRECTOR'S ABILITY TO MANAGE VAMC RESOURCES DUE TO THESE LAYERS OF COMMAND.

3. I believe you stated in your testimony that the means test should apply to all non-service-connected conditions. Is this an accurate reflection of VVA views?

THAT SYSTEM WHICH WOULD BEST SERVE THE VETERAN WOULD BE ONE WHICH ALLOWS THE VETERAN WITH HIS/HER CARD IN HAND TO HAVE THE HEALTH CARE PROVIDER OF CHOICE. BARRING THAT AS A POSSIBILITY AT THIS TIME AND GIVEN THE SYSTEM THE VETERAN IS FORCED TO DEAL WITH, MEANS TESTING FOR ALL NON-SERVICE CONDITIONS AND TOTAL ACCESS FOR ALL SERVICE CONNECTED CONDITIONS IS A VIEW WE SUPPORT.

Should those veterans (with non-service-connected conditions) receive care only on a space available basis?

THESE VETERANS SHOULD RECEIVE CARE, ESPECIALLY AFTER THE VA ACCEPTS RESPONSIBILITY FOR THEM, IN A MANNER WHICH DOES NOT ADVERSELY EFFECT HIM/HER. OUR EXPERIENCE IS THAT "SPACE AVAILABILITY" IS FAR LESS PAINFUL TO THE VETERAN THAN "PERSONNEL AVAILABILITY."

4. When did the VVA become aware of the VA funding problem? What did your organization do to bring this issue to light?

VVA, AS PREVIOUS HEARINGS INDICATE, HAS BEEN AWARE THAT THE VA HAS HAD A FUNDING PROBLEM. WE HAVE OFTEN SIGNALED THAT VA FUNDING IS AS MUCH A PROBLEM OF HOW THE VA USES ITS DOLLARS AS THE ADEQUACY OF DOLLARS APPROPRIATED. FURTHER, WE WERE FULLY AWARE (ESPECIALLY WITH REGARD TO THE FISCAL YEARS '88 AND '89 FUNDING SHORTFALLS AS NOTED BY THE DEPARTMENT OF MEDICINE AND SURGERY WHILE THE ADMINISTRATOR DID NOT AGREE WITH SUCH NOTATIONS) THAT OUR COLLEAGUE VSO'S WERE BRINGING TO LIGHT EARLY IN THE GAME THE ISSUE OF FUNDING FOR THE VA HEALTH CARE SYSTEM. OUR RESPONSIBILITY THEREFORE, IN CONJUNCTION WITH OUR COLLEAGUES WAS TO PRESENT ALONG WITH THE NOTION OF THE LACK OF FUNDING, THE ISSUE OF HOW THESE FUNDS ARE USED. WE CANNOT GO ON FOREVER AND EVER ASKING FOR MORE AND MORE MONEY WITHOUT EXPLORING WAYS TO SPEND LIMITED RESOURCES WISELY.

Hopefully these responses have addressed your questions fully. Should you have any further questions, please feel free to contact the VVA once again.

As always, your attention to the views of the VVA is appreciated.

Sincerely,

Thomas A. Sherwood
Director, Health Policy and
Planning

Mary Stout
Mary R. Stout
President

Vietnam Veterans of America
2001 S St NW
Suite 700
Washington DC 20009-1125

(202) 332-2700

October 3, 1988

Senator Frank H. Murkowski,
Ranking Minority Member
Senate Committee on Veterans' Affairs
SH-202 Hart Senate Office Building
Washington, DC 20510

Dear Senator Murkowski:

This letter will respond to your follow-up questions arising from the Committee's hearing on September 9, 1988. We apologize for the tardiness of this response to your questions and appreciate your thoughtfulness in favoring the VVA with the follow-up questions.

1. You stated in your testimony that it is impossible for the very highly centralized VA health care system to provide quality health care. Yet we heard the PVA state that the VA system was too decentralized.

A. What is your reaction to the PVA position on this issue?

During the hearing our understanding was that the PVA was referring to the VA's inability at the local hospital level to make decisions without relying on higher decision-making levels for guidance. Under the circumstances described by the PVA, as we understand them, the reference to an overly decentralized system was based upon an acknowledgement that while local decision-making does take place, the decisions themselves can only be relied upon once they are endorsed by higher level VA authorities. Ironically, the VVA would agree with the PVA that local hospital decisions are too controlled by higher authorities within the health system. Under the circumstances, and in spite of the PVA's use of the terms "too decentralized", the VA system is by definition too centralized. Where we may differ from the PVA is that we firmly believe unfettered decision-making should appropriately reside with those with the clearest understanding of local hospital conditions. Since hospital directors are instead hampered by District, Region and Central Office decision-makers, we believe some serious changes are in order.

2. You support the elimination of VA medical regions. What would be the objective of such an action?

As implied in the response to the first question, the reason for eliminating the medical regions is to better facilitate hospital responsiveness to local medical needs and to further facilitate the weighting of concerns for quality of care over quantity of care in individual hospitals. By eliminating the regions, we believe there would be less interference in the vital interactions between hospital providers of health care and the VA Central Office. In this connection, our prescription for the most ideal relationship between the hospitals and the Central Office is one in which the VA Central Office purchases the care offered by local hospitals by affording specific allocations of resources. Under this prescribed relationship, the individual hospital director would prepare his or her own local hospital budget and negotiate with medical districts over the details.

The seven VA medical regions, in our view, have become overly cumbersome with only limited usefulness. The medical regions seem to have evolved into seven mini-Central Offices exerting unnecessary demands on local hospitals at the expense of quality care and decisiveness in responding to local medical exigencies. Additionally, as noted in our testimony and certainly not least in importance, the Central Office uses the regions to shelter itself from corporate responsibility and accountability.

3. I believe you stated in your testimony that the means test should apply to all non-service-connected conditions.

A. Is this an accurate reflection of the VVA's views?

The VVA's preference on the question of availability of health care, especially in the cases of veterans with compensable service-connected disabilities, is to allow veterans access to providers of choice with payment for care assumed by the VA. Having said that, it appears unlikely for a variety of reasons that this particular option is possible in the foreseeable future. Assuming this to be true, the VA health care system can expect to experience increasing and undiminished demand for health care services by both service disabled and non-service disabled veterans over the next several years. Unless large new infusions of federal capital are provided, a highly unlikely eventuality, choices will have to be made as to who will and who will not receive desired services in an overloaded health system.

As a suggestion in our statement for the September 9, 1988 hearing to address the squeeze on care availability, we offered the option of limiting non-means tested care to only those veterans requesting VA health care for medical problems directly related to their service-connected conditions. In other words, conditions suffered by service disabled veterans that are unrelated to the conditions for which service connection was granted should be subject to the means test.

B. Should those veterans receive care only on a space available basis?

This is an important question as it relates to the quality of care available to veterans who use the system. However, if quality of care is used as a goal instead of quantity of care, the question of space availability becomes less significant. If the VA admits a patient to its care, but lacks sufficient staffing to afford high quality care, the fact that the VA had a bed available to which a veteran could be admitted is irrelevant. In the VVA's view, and we hope you agree, if the VA accepts a patient into its care, the care given should be complete and it should be of high quality.

It is our opinion that the quality of care in VA facilities has been mistakenly taken for granted as VA and Congressional policy-makers have sought to maximize the quantity of care available. The use of quantity as a measure of VA's fulfillment of its mission must be de-emphasized.

4. When did the Vietnam Veterans of America become aware of the VA funding problems? What did your organization do to bring this issue to light?

On the general subject of funding shortages, it is important to note that the VVA has never asserted that too little was being spent on health care. Instead the VVA has consistently stated that resources have been inappropriately targeted. On the specific question of funding shortages causing the current problem in which even service disabled veterans are turned away due to poor staffing, the existence of too many mere shadow beds and, in some cases, the closing of entire inpatient units in some hospitals, the VVA has stated its suspicions on a variety of occasions before each of the Veterans' Affairs Committees over the course of the last several years.

More recently, however, our suspicions were confirmed by the preliminary results of a House Veterans' Affairs Committee survey. These results were compiled in a Committee Print dated May 31, 1988.

Hopefully, these questions have been addressed to your satisfaction. Should you have further follow-up questions, we would welcome the opportunity to address them. As always, your attention to the views of the VVA is appreciated.

Sincerely,

Mary R. Stout
President

Regional Director
Northeastern Region

P.O Box 8500
Albany, N.Y. 12208

Veterans
Administration

September 22, 1988

Honorable Frank H. Murkowski
Ranking Minority Member
Committee on Veteran's Affairs
United States Senate
Washington, D. C. 20510-6375

Dear Senator Murkowski:

Enclosed please find my response to the follow-up questions contained in your letter of September 15, 1988.

I appreciate the opportunity to respond to these questions in light of our mutual concern with preserving a quality health care system for our nation's veterans.

Sincerely,

AL WASHKO
Regional Director
Northeast Region

Enclosures

In Reply Refer To:
(10BA1)

QUALITY: Our Highest Priority
Manage It — Reward It

QUESTION 1:

Do you believe that there is a need to examine the mission of the VA Health Care System in terms of looking at every facility to determine if 1) it is needed 2) it's mission should change, 3) it could be consolidated with another facility?

In the absence of major budget increases, there is a need to look at the mission of some VA Medical Centers for the purpose of reducing services.

Our primary commitment to our veteran patients is to provide quality care. If we cannot meet quality standards at all facilities due to resources being constrained or spread too thin we must look for ways to operate more cost efficiently while maintaining quality in those programs that we offer.

All VA Medical Centers provide needed care but not all VAMCs are needed in their present capacity given our current level of resources to meet the current and projected workload. For example, in several large metropolitan areas the VA operates multiple VAMCs that offer overlapping services. With the increased emphasis on alternatives to acute bed care and reduced length of stay, the VA may no longer need all of our current acute care bed capacity. We do, however, project increasing needs for long term care beds (Intermediate Medicine and NHCU) due to the aging veteran population.
It stands to reason that in cities with three to four tertiary level VAMCs at least one of the VAMCs could be given the mission of secondary plus long term care. This would allow some of the acute care resources to be reprogrammed either to upgrade acute care services at the remaining tertiary care facilities or to improve long term care capabilities. Another option would be to convert one of the medical centers to long term care plus outpatient services. Both of these options would have minimal impact on the veteran receiving health care. He or she would still come to the usual medical center for routine care and be referred to a higher level center only when more specialized care was indicated.

A third option would be to close one of the medical centers entirely and use the resources to provide quality services at the other medical centers. This may be possible in Boston or New York and other large cities.

While we have pursued the above strategies, usually through our Medical District Initiated Planning Process (MEDIPP), we have been discouraged by the results. The political process usually stops rational planning of this sort. Examples are: VA proposed mission change to Walla Walla, Washington in 1986 and the VA proposed closing of a small satellite clinic in New Bedford, Massachusetts.

PART II

If yes, how should such an examination take place?

Veterans health care needs should be the first consideration in any mission review process. This can be accomplished by projecting total health care needs on a district rather than a VAMC basis. The next step after total health care needs are estimated would be to evaluate alternatives necessary to meet those needs i.e., surgical services at all VAMCs or just a few, how many VAMCs should offer dialysis, neurology, rehabilitation medicine, etc.

To be effective, this review would require the commitment and participation of top managers at all district facilities and their affiliates, as well as, agency and congressional support. We can not minimize the impact of changing missions on our affiliated institutions who may have a vested interest in maintaining programs or on Congresspersons who usually resist changes which result in decreased programs or resources in their district.

In summary if the VA is to provide the quality of care our veterans deserve, we must either obtain additional resources or reduce services. If we must reduce services we should do so in a manner that least impacts on our veteran patients. The latter can be accomplished by mission change, consolidation and closure of VAMCs consistent with patient care needs, on a district basis with the support of the Congress.

QUESTION 2:

How much flexibility do you have to reallocated money within hospitals in your region? Do you have enough flexibility or is more needed in order to operate the system more efficiently?

The Regional Director has flexibility to move funding between medical centers within most analysis accounts. Regional Directors can also move money between analysis accounts for equipment, NRM projects and all other. Restrictions to the Regions remain in several areas including an FTEE ceiling, a salary floor and employee travel.

There is a need for Regional Directors to have more flexibility in several areas.

FTEE ASSIGNED CEILING AND SALARY FLOOR

Because we are a labor intensive industry, the most feasible way of addressing budget reductions is adjusting FTEE. Congressional assignment of an FTEE floor greatly restricts management's ability to make budget adjustments. In addition, maintaining Congressionally assigned employment levels at the expense of equipment and maintenance projects ultimately affects patient care and recruitment efforts for key medical staff. Nationwide there are many positions that are very difficult to recruit and temporary employees are hired in order to meet the assigned ceiling. There are instances where these salary dollars could be better utilized for other hospital needs if these restrictions were removed.

EMPLOYEE TRAVEL

The Department of Medicine and Surgery is restricted on the amount of funding that can be spent on employee travel (.007). Throughout the year Medical Center Directors require additional employee travel funds from the Regions which often are disapproved because no travel funds are available in the Region. The Regional Director has funding available for other clinical emergencies/needs, but because of the restrictions imposed, the travel account cannot be supplemented.

QUESTION 3:

What is your view of the VA's Resource Allocation Methodology? What changes need to be made in the RAM in order for it to achieve its intended purpose?

The current RAM has made several contributions to the management of VA health care. It has established a quantitative methodology for allocating limited resources between medical centers. The RAM uses relative efficiency as the criterion for distributing resources. VA management has responded to these incentives for increased efficiency in a number of positive ways. The workload and cost data being reported by managers and used by the RAM has improved. In addition, lengths of stay have declined, medical product definitions have improved and efforts to cost these medical products have increased. However, because efficiency is the sole criterion used by the RAM in allocating resources a number of problems have arisen.

Linkages must be established between RAM and quality assurance.

Efficiency as rewarded by the RAM is defined as a maximization of workload with a minimization of costs. The problem with this definition is that it fails to define the quality of the product produced. Conflicts exist between optimum care and profit motives. The RAM needs to incorporate incentives for optimum care as well as efficiency. Without sufficient links between RAM and quality assurance the RAM may be rewarding the least costly care but not necessarily quality care. The VA needs to establish measures of quality and standards of care as well as measures of efficiency in order to produce the optimal output-quality combination for optimal care of veterans. Efforts to maximize workload without additional funds will in all likelihood impact on the quality of care. Until a mechanism can be built into RAM to control workload growth as well as measure quality of care, the models incentives will collide with the Department's budget and patient care will suffer.

The three RAM Models need to be integrated in order to produce unified patient care.

The structure of the current RAM segments patient care into three models, inpatient, outpatient and long term care. This segmentation produces disjointed patient management rather than a unified approach to patient care. In addition, certain types of inpatient hospitalization are encouraged over alternative modes of care distorting the balance which should exist between acute, outpatient and long term care.

The RAM model should not be used as a substitute for management judgement in allocation decisions.

If allocations are based solely on the RAM, dollars will flow to the least costly hospitals. Those hospitals producing high cost products may choose to eliminate these products in order to maintain financial viability. In addition, other short term profit maximizing behaviors may occur which may not be good for overall veteran health care. The RAM should not be allowed to substitute for managerial judgement including long term policy decisions regarding the veterans that should be served, the types of care which will be produced and the quality level of that care. Allocation decisions must begin by clearly defining agency priorities. The RAM should be used as a tool to bring about behaviors consistent with agency priorities rather than allowing the RAM to become the defacto policy maker for the agency.

Better cost and workload data bases are needed to improve the RAM:

The RAM is limited as a resource allocation tool by our inability to measure true costs and quality in the VA. Under the VA's current cost accounting system only average costs can be calculated. For example, DRG 426, Depressive Neurosis costs, on the average, the same as DRG 127 Heart Failure and Shock. However, the true cost for a specific patient in DRG 127 or 426 cannot be determined. Without the knowledge of true costs behaviors are often distorted and the incentives intended by the RAM are distorted as well. Ideally, if the cost of producing each product were known, an appropriate reimbursement price could be set. The adjustment of reimbursements relative to costs as well as quality would create the incentives necessary to produce behaviors consistent with agency goals.

Veterans
Administration

September 21, 1988

In Reply Refer To 10BA4

Honorable Frank H. Murkowski
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510-6375

Dear Senator Murkowski:

Enclosed are responses to the questions for the record. I appreciated the opportunity to testify at your hearing and to provide you and your Committee with this information about the Veterans Administration's plans to address our budget shortfall.

Please let me know if I can provide any additional assistance.

Sincerely,

A Zamberla

A. ZAMBERLAN
Regional Director
Great Lakes Region

Enclosure

Questions Submitted by Senator Frank H. Murkowski

1. Do you believe that there is a need to examine the mission of the VA health-care system in terms of looking at every facility to determine if 1) it's needed, 2) its mission should change, or 3) it could be consolidated with another facility.

- If no, can VA afford to keep doing business as usual?
- If yes, how should such an examination take place?

Response:

The alternatives being presented to address the FY 89 budget shortfall have concentrated on actions that could be implemented within a very short timeframe. I agree that the issues of facility missions and hospital closures and consolidations needs to be explored as the long-term solution to our financial difficulties. We cannot continue to use short-term solutions that erode our physical plants and equipment, nor do we endorse this concept.

We have in place an extensive planning process which is an appropriate forum to study mission changes. The information and recommendations afforded us through MEDIPP must be addressed by a broad constituency group, as recommended by the CMD's task force on the FY 89 budget, including members of Congress, veterans service organizations, AAMC and broad departmental review to ensure support for changes that must be made. Such a group would be similar to the blue ribbon panel appointed by the Congress to recommend the closure of DOD military bases.

2. How much flexibility do you have to reallocate money within hospitals in your region?

- Do you have enough flexibility or is more needed in order to operate the system more efficiently?

Response:

The flexibility to divert funds within facilities is contingent upon the amount of non-recurring equipment and maintenance and repair funds allocated to a facility. Other non-recurring funds are in restricted accounts, such as fee medical and dental, contract hospital, and community nursing home. We are also severely constrained by the personal services floor and FTEE ceilings mandated by the Congress. As I testified before the committee, the requirement to maintain our FTEE expenditures and ceiling has produced a personal services level that is out of sync with the operating funds needed to support them.

3. What is your view of the VA's Resource Allocation Methodology? What changes need to be made in the RAM in order for it to achieve its intended purpose?

Response:

We believe that the RAM equitably distributes resources based upon facility complexity and efficiency, and has been a valuable management tool since its inception. However, the current environment of restricted budgets and rising staffing and medical inflation costs necessitates a change in some of the goals and objectives of the RAM. We must eliminate incentives to increase workload and build in a quality of care measure. If these modifications cannot be developed and implemented in a very short period of time, the RAM should be suspended for resource allocation purposes. The model must be flexible enough to adjust to the changing constraints on the VA system, and reward those facilities most adept at providing high quality, cost-effective care to eligible veterans.

ARLEN SPECTER
PENNSYLVANIA

COMMITTEES
JUDICIARY
APPROPRIATIONS
VETERANS AFFAIRS
INTELLIGENCE

United States Senate
WASHINGTON, DC 20510

September 21, 1988

The Honorable Thomas K. Turnage
Administrator
Veterans' Administration
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Administrator Turnage:

Thank you for your participation in the Senate Veterans' Affairs Committee hearing regarding funding of Veterans' Administration (VA) medical care. I believe all parties involved in the hearing benefited from the opportunity to exchange views on this important issue.

I am writing to follow up on an issue which was raised during my questioning of Mr. David W. Gorman of the Disabled American Veterans (DAV). As you may recall, my line of questioning was intended to determine how responsive the VA is when a specific problem is brought to the attention of VA personnel. The witnesses indicated that, for the most part, the VA is responsive in these situations -- with one exception. According to Mr. Gorman, the DAV, as well as the other veterans' service organizations, have had repeated difficulties in obtaining prosthetics for veterans in a timely manner (hearing stenographic transcript, page 66).

At that time, I requested that you respond to Mr. Gorman's statement regarding prosthetics. I remain interested in receiving your thoughts on this important issue.

Thank you for your attention to this matter.

Sincerely,

Arlen Specter

AS/ls

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

OCT 24 1988

Honorable Arlen Specter
United States Senate
Washington, DC 20510

Dear Senator Specter:

This is in response to your letter of September 21, 1988, regarding the issue of obtaining prosthetics for veterans in a timely manner which was raised by Mr. David Gorman of the Disabled American Veterans during the Senate Veterans' Affairs Committee hearing on September 9, 1988.

We share the concerns of the Disabled American Veterans, as well as other veterans' service organizations, about veterans having difficulties in obtaining prosthetic services in a timely manner. We believe that these difficulities can and will be resolved.

In June 1988, the Department of Medicine and Surgery organized and appointed a Prosthetics Task Force to address the growing interest in the adequacy of funding levels at our medical facilities and the effectiveness of the management of our prosthetics program. Chaired by Dr. Carl L. Gerber, M.D., Director, VA Medical Center, Fort Meade, South Dakota, the Task Force membership includes:

George Moore, Assistant Director, VA Medical Center Cleveland
Frederick Downs, Jr., Director, Prosthetic and Sensory Aids Service, VA Central Office
Peter Altner, M.D., Director, Comprehensive Rehabilitation Center, VA Medical Center, Northport
David Rutledge, Resource Management Office, VA Central Office
Mona Hush, Office of Acquisition and Materiel Management, VA Central Office
Don Pratt, Health System Specialist, VA Central Office

A survey of all medical facilities has been conducted to determine the extent of prosthetic funding and management problems. The Task Force met October 12 and 13, 1988, to review and analyze the survey responses. When their analysis is completed, the Task Force will submit their recommendations to the Associate Deputy Chief Medical Director for improvements in the prosthetic funding process, management, staffing, training and organizational matters.

Your interest and concern in this matter are deeply appreciated. I share your strong desire to attain meaningful improvement on this important issue.

Sincerely,

THOMAS K. TURNAGE
Administrator